

Services for Young People

A Review of Stakeholder Experiences

EU/UNFPA

Reproductive Health Initiative for Youth
in Asia (RHIYA) 2007

Editorial team

COORDINATORS: Thierry Lucas, Jason Edwards
LEAD RESEARCHER & AUTHOR: Catharine Taylor
RESEARCHERS: Helen Maw, Juliette Boog
EDITOR: Corrie Mills
DESIGNER: Lex Wilson

based on the original design of Louise Scovell

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The photos illustrating this publication are from the project sites themselves unless otherwise stated in the caption.

Cover image: © Karen Robinson / Panos Pictures
Children playing in jute crops, Tangail, Bangladesh

At the International Conference on Population and Development (ICPD) held in Cairo in 1994, 179 governments affirmed that ensuring access to reproductive health services and guaranteeing reproductive rights is essential to achieving broader development goals. Recognizing that the sexual and reproductive health needs of adolescents were not being met, the ICPD Programme of Action calls on governments, donors and civil society to work together to ensure that young people are equipped with the information and skills necessary to make a healthy transition to adulthood.

Nowhere is the challenge to fulfil the rights of young people to sexual and reproductive health more critical than in Asia, home to 70 per cent of the world's 1.5 billion young people aged 10-24 years. In many countries in South and South-East Asia, young people make up from one third to one half of the population.

Despite rapid changes in lifestyles, attitudes towards young peoples' sexual and reproductive health have not changed, leaving young people unprepared to make healthy decisions. The results are clear: worldwide young people accounted for 40 per cent of new HIV infections in 2006. The most striking increases have occurred in Asia and in Eastern Europe, where the number of people living with HIV in 2006 was 21 per cent higher than in 2004.

Through the EU/UNFPA Reproductive Health Initiative for Youth in Asia (RHIYA) the European Commission and UNFPA have partnered with seven national governments and civil society organizations to respond to the significant challenge of addressing the rights of young people to education and sexual and reproductive health. RHIYA has pioneered unique approaches and deployed a range of innovative activities to create opportunities for young people to protect their sexual and reproductive health, so that they may meet their full potential. In addition to developing successful methods to reach young people, RHIYA has contributed to developing national capacities to plan, manage and monitor programmes and to increase national commitment and investments in responding to the needs of young people within the frameworks of national plans and policies.

The purpose of this publication is to share the rich and varied experiences from RHIYA so that they may be used as a valuable resource within the seven countries and beyond. At the same time, it marks our pledge to continue to work in this important area. The World Summit in 2005 reaffirmed that the eradication of extreme poverty and hunger cannot be achieved if we do not invest more in education and health, including sexual and reproductive health. Young people must be at the centre of these investments.



Thoraya Ahmed Obaid

Executive Director of the
United Nations Population Fund



Benita Ferrero-Waldner

Member of the Commission of the
European Communities, responsible for External
Relations & European Neighbourhood Policy

Abbreviations

AIC	Adolescent Information Corners
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ASRH	Adolescent Sexual & Reproductive Health
A/Y	Adolescent/Youth
BCC	Behavioural Communication Change
CBO	Community Based Organization
CDA	Centre for Development Alternatives
COPE	Client Oriented Provider Efficient
CSW	Commercial Sex Workers
EU	European Union
FPAB	Family Planning Association of Bangladesh
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
MCH	Maternal and Child Health
MOH	Ministry of Health
MOHFW	Ministry of Health & Family Welfare
MSI	Marie Stopes International
MSS	Marie Stopes Society
NGO	Non-governmental Organization
PAVHNA	Pakistan Voluntary Health & Nutrition Association
PE	Peer educator
PHECT	Public Health Concern Trust
PNC	Post-natal Care
PRSP	Poverty Reduction Strategy Papers
PSL	Population Services Lanka
RH	Reproductive Health
RHAC	Reproductive Health Association of Cambodia
RHIYA	Reproductive Health Initiative for Youth in Asia
SACHET	Society for the Advancement of Community Health, Education and Training
SDP	Service Delivery Point
SRH	Sexual & Reproductive Health
STI	Sexually Transmitted Infection
UN	United Nations
UNFPA	United Nations Population Fund
UPSU	Umbrella Project Support Unit
YFC	Youth Friendly Centre
YFHS	Youth Friendly Health Services
YFSDP	Youth Friendly Service Delivery Points
YIC	Youth Information Corner

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The EU/UNFPA Reproductive Health Initiative for Youth in Asia (RHIYA) is a regional programme seeking to improve the sexual and reproductive health of young people aged 10-24 in 7 countries in South and South-East Asia. The RHIYA programme commenced activities during 2003 and ended in December 2006. Over the course of the three years, the programme's activities reached in excess of two million young people across the region.

The programme's main activities related to:

- * **Information, Education and Communication:** to increase awareness of adolescent and youth sexual and reproductive health (SRH) issues in society as a whole, to promote healthy behaviour and, where appropriate, to address gender-based violence and trafficking of women and girls.
- * **Provision of quality services:** from counselling and prevention to primary care, including access to contraception, HIV/AIDS prevention and management of sexually transmitted infections (STIs).
- * **Capacity building:** to develop civil society and non-governmental organizations, public sector and local community partnerships, to provide youth friendly information and SRH services.

STAKEHOLDER REVIEW

This paper reflects the experiences and opinions of the stakeholders involved across the 7 RHIYA countries. Throughout the paper, reference is made to stakeholders. Those interviewed for this review included young people, peer educators, project staff, local leaders, parents, staff from the Umbrella Project Support Unit (UPSU) and central government personnel.

This booklet is part of a series arising from a review commissioned to explore and evaluate how two cornerstone approaches of RHIYA's programme – peer education and services for young people – were implemented across the 7 RHIYA countries: Bangladesh, Cambodia, Lao PDR, Nepal, Pakistan, Sri Lanka and Viet Nam.

The review exercise was carried out between 2006 and 2007 by three international consultants from HLSP guided by UNFPA experts and RHIYA teams.

The resulting publications are:

- * **Two full reports**
 - Peer Education –
A Review of Stakeholder Experiences
 - Services for Young People –
A Review of Stakeholder Experiences
- * **Two summary booklets**
 - Positive Pressure –
Learning from Peer Education Experiences
 - A Place of Our Own –
The Benefits of Services for Young People

These four publications complement the wealth of quantitative and qualitative information on RHIYA's achievements available through the four Good Practice Guides and accompanying Case Studies, the series of country-based Monitoring and Evaluation Reports, and through a forthcoming publication synthesizing the RHIYA programme achievements.

'**Services for Young People – A Review of Stakeholder Experiences**' was conducted with the aim of providing policymakers, programme managers and development professionals with an account of how services for young people as a programming approach were implemented across the RHIYA countries. It further aims to assist programme managers and staff in planning future programmes. This report focuses on the perspectives of the stakeholders themselves and their experiences, including young people, project managers and staff, local officials, religious leaders, teachers, parents and health staff. The consultants carried out the review to present a profile of the services provided and the factors which lead to the successful deployment of the approach to improve sexual and reproductive health (SRH) outcomes for young¹ people. It should be noted that this review does not aim at statistical sampling or representativeness of the services, but aims to complement the quantitative data with reflection based on the qualitative interviews undertaken.

Since ICPD, development and health professionals, and policymakers have designed and delivered services based on the assumption that adolescents and young people's developmental and health needs are specific and distinct from adults. It is acknowledged that information, counselling and health services for young people need to differ from those provided for adults. More recently services have also taken into consideration the broader development needs of young people and have established linkages with sectors such as education, vocational training and income generation.

The RHIYA programme provides an excellent opportunity to explore the multifaceted aspects of programming, with many projects combining activities that aim to address the information, psychosocial and health needs of young people. This report takes the reader through the responses and the processes involved in implementing services for adolescents² and youth³, including what seemed to work and what did not work so well.

The review of stakeholder experiences from RHIYA projects reaffirms the importance of tailoring services to meet the diverse needs of young people from different age groups, sociocultural and economic backgrounds. The interviews clearly demonstrate the need to:

- constantly experiment with different approaches to attract young people into the services.
- involve young people as active participants in the design and provision of their own services.
- approach the needs of young people in a holistic and adaptive manner.

Report structure

A wide range of services were provided to address the SRH and development needs of young people within different settings. This report reviews the services provided as part of the RHIYA programme, distils lessons learned and attempts to understand the challenges faced in operationalizing services. The report concludes with a section covering important issues to consider when implementing SRH services for adolescents and youth.

The report can only provide a 'snap shot' of the RHIYA programme and can in no way capture the richness and diversity of the RHIYA programme approaches nor can it adequately demonstrate the commitment and innovation of the staff and stakeholders directly involved in the programme. The views expressed in this report are those of the author and do not necessarily represent those of the UNFPA.

¹ Young People defined as: 10-24 year olds (UNFPA)

² Adolescents defined as: 10-19 year olds (early adolescence 10-14 and late adolescence 15-19) (UNFPA)

³ Youth defined as: 15-24 year olds (UNFPA)





Introduction

DEVELOPMENT OF THE SRH CONCEPT AND ITS DEFINITION

Introduction

“ SRH is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice of regulation of fertility which are not against the law, and the right of access to appropriate health services that will enable women to go through pregnancy and childbirth and to provide couples with the best chance of having a healthy infant... full attention should be given to ...meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.”

(Source: Programme of Action adopted at the ICPD, Cairo, 5-13 September 1994 7.2 and 7.3 , page 44 and 46)

The shift from family planning (FP) towards reproductive health took place in the 1990s. The change came about due to the growing concern that FP programmes tended to overlook, or even violate women's reproductive rights, and did not address the holistic nature of SRH and the well-being of both men and women as individuals. It was also a watershed moment of moving away from a target based 'demographic' perspective. Furthermore, there was an acknowledgment among policymakers and FP programmers that programme effectiveness was dependant on the quality of care provided and the range of SRH services offered⁴.

The International Conference on Population and Development (ICPD) in 1994 set an ambitious Programme of Action, based on a comprehensive definition of reproductive health that included sexual health. The Programme of Action noted that signatory 'countries', with the support of the international community, should protect and promote the rights of adolescents to SRH education, information, and care⁵. More recently, the Millennium Development Goals acknowledged the specific needs of young people for gender equity and equality, education, safe pregnancy, and reduction in the spread of STIs and HIV/AIDS⁶. The Declaration of Commitment signed at the UNGASS committed governments to meeting specific goals to fight HIV/AIDS among young people⁷. They agreed to:



| 2 Group of young women, RHIYA, Sri Lanka

“ensure that at least 95 per cent of young men and women age 15 to 24 have access to the information, education, including peer education and youth specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection by 2010.”

The needs of adolescents and youth have been recognized and, now that it is understood that the health and development needs of young people (including SRH) have a profound effect on the health indicators for the population as a whole, programming in SRH has commenced. SRH information and services are considered to encompass all issues related to sexuality (masturbation, puberty, wet dreams, love and friendship, sexual dysfunction) contraception services, safe abortion (where legal), safe motherhood, STIs and HIV/AIDS, although HIV/AIDS is considered as a communicable disease and treated separately from SRH.

⁴ Hardon A, et al Manual - Applied Health Research, Anthropology of Health and Health Care. 1995, page 89.

⁵ ICPD Programme of Action www.un.org/popin/icpd/conference/offeng/poa.html

⁶ www.developmentgoals.org

⁷ United National General Assembly Special Session on HIV/AIDS. Declaration of commitment on HIV/AIDS. Geneva: United Nations, 2001.

Development and definitions of services for young people

‘Services for young people’ can encompass a range of different programming approaches aimed at improving the SRH of adolescents and youth. The range of interventions can be broadly categorized as:

- **YOUTH CORNERS** – providing information and education materials
- **YOUTH CENTRES** – providing a range of information but also vocational training and skills building, sports facilities and counselling
- **YOUTH FRIENDLY HEALTH SERVICES** – preventative health services in static clinics and outreach services, access to contraception and STI prevention and treatment services, voluntary counselling and testing (VCT) services for HIV/AIDS, and general health services.

These services are provided within a mutually reinforcing package of interventions, which includes peer education and mass media. Peer education and mass media approaches are covered in detail in the **RHIYA Good Practice Guides** and the **Peer Education Stakeholder Review**.

Across the RHIYA countries, the majority of young people begin their sexual lives within marriage. However, due to the increasing sociocultural and economic changes within these countries, more young people are staying at school longer, entering university, joining the workforce outside their immediate communities and marrying later. Therefore the number of young people potentially engaging in sex before marriage is increasing.

A WHO review of literature and projects on adolescent and youth SRH in several countries in East and South-East Asia, between 1992 and 2005, noted evidence of premarital sex activities, unwanted pregnancies, abortion, STIs and HIV/AIDS⁸.

The RHIYA programme aimed to prepare young people for their reproductive lives, by providing access to information which is correct and tailored to young people’s needs, so that they understand the choices available to them. Having access to this information should help protect their SRH and promote gender equity, build life skills and increase their options through vocational and social activities.

The programme also addresses the needs of more vulnerable young people who are at risk of early pregnancy, gender-based violence, STIs and HIV/AIDS, and who follow lifestyles which increase their exposure to alcohol and drug use. In addition, RHIYA supported government policy formulation in order to strengthen the enabling environment for service provision for young people.

The challenge for the RHIYA programme has been the need to generate new knowledge while piloting different programming approaches in many different settings. There is an urgent need to generate new knowledge as a result of a general lack of research and data available in the field on issues, such as the needs of different age groups, the differences between rural and urban youth and the needs of more vulnerable young people. In addition, the environment within which programmes operate is not always enabling, as government policies related to youth SRH can be restrictive and/or weak. In some countries, the needs of young people are not a priority as governments continue to struggle to provide quality SRH information and services for their adult populations. Championing services for young people within communities remains challenging. Sociocultural barriers and long standing traditional beliefs and values related to SRH fail to acknowledge young people’s changing needs.





The review

REVIEW METHODOLOGY

Briefing: The consultants were briefed by the UNFPA RHIYA Central Unit in Brussels.

Literature review: The consultants reviewed the youth services literature to better understand the contexts in which services programmes were implemented and the processes involved in establishing services for young people.

Mapping for the services: In advance of the country visits, youth services matrices were developed from the quarterly and annual project reports. A matrix was developed for each project and included information on the service characteristics considered important for the implementation of effective services (as identified in the literature review).

Country context: The consultants prepared a country context sheet for each RHIYA country to help prepare the reviewers. The purpose was to assemble a summary of key contextual items directly relevant to young people's SRH rights. The country context was the background against which the review could be undertaken and it created a basis for recognizing the different and contrasting SRH realities for adolescents and youth. For instance, in one country establishing a youth centre might be a major achievement, whereas in countries where the provision of health services for young people is already accepted the focus was on supporting government to scale up quality youth services.

Development of the tool: A methodological framework setting out the key issues to be investigated was developed and applied by all three consultants during their fieldwork in the RHIYA countries. As appropriate, the consultants adapted the methodology to the country and sometimes as the fieldwork progressed – the youth services tool is provided in Appendix 2.

Fieldwork: Each of the 7 RHIYA countries were visited between December 2006 and April 2007. Country visits began with a briefing session, in which the UPSU and in-country RHIYA partners were informed about the objectives and approach of the research. The UPSU staff provided an overview of their work and the work of the implementing partners.

Sampling: All consultants conducted fieldwork across a broad cross-section of programme settings. The fieldwork was facilitated by the UPSU staff, who made the fieldwork agenda and assisted in the logistics including briefing field staff. The UPSU staff were asked to select those settings that represented a typical profile of youth services in their respective countries. The consultants visited as many youth services sites as possible within each country. In most of the countries, this included a representation of geographical variation (rural, semi-urban and urban) different target groups (in and out of school, ethnic minority groups etc) and different services, as identified from the project documents. The young people interviewed were mainly aged 15 years or over and included a balance of girls and boys, more urban than rural youth, and more out of school youth.

Interviews: In-depth, semi-structured interviews were the main research tool used. Each interview took on average 1.5 to 2 hours. The tool was used to guide the interview, but the interviewees were encouraged to voice their opinions and experiences in a manner that most suited them as individuals. A cross-section of stakeholders was interviewed at each project site, including young people, project staff, health staff, religious and community leaders. Wherever possible, interviews were conducted on an individual basis, although on occasion two stakeholders from the same group had to be interviewed together for logistic purposes e.g. young service users. Interviews were then transcribed as soon as possible.

Debriefing: At the end of the country visit each consultant wrote a debriefing note of their initial impressions, which they provided for the UPSU.



STRENGTHS OF THE REVIEW METHODOLOGY

- Triangulation of results – interviews were conducted with a number of different stakeholders at each site.
- The interviews were conducted without the presence of project staff.
- Use of ‘purposeful’ sampling – the UPSUs had been requested to select information rich cases or sites for the fieldwork.
- A unique opportunity to review the operationalization of youth friendly service approaches in 7 different countries and within these a variety of project areas.
- RHIYA has a large database of project reports easily accessible for cross-referencing.

LIMITATIONS OF THE REVIEW METHODOLOGY

- Most of the RHIYA projects had closed down, so the consultants were not able to visit the actual project activities and interaction between staff and young people could not be observed. All the interviews were retrospective.
- Not all RHIYA projects were visited as part of the review.
- Some interviews had to be interpreted and the quality of the interpretation could not be verified thereby affecting the quality of the information.
- The long interviews meant that some stakeholders had to wait for long periods of time.
- Project staff and local officials selected the stakeholders for interview, which introduced bias.





What About Us?

The need for services
for young people





KEY POINTS COVERED IN THIS SECTION:

- Despite a clearly identified need, young people have limited access to SRH services – particularly in rural areas.
- Gender, age, marital status, location and income all impact on young people's ability to maintain their SRH and access services.
- Traditional gender stereotypes emphasizing the dominant male role in SRH issues are barriers to empowering young girls to improve their SRH.
- Currently NGOs provide many services for young people, but increased government capacity to provide youth friendly services is essential in ensuring long-term sustainability.
- Through advocacy efforts on the part of both the RHIYA programme and other organizations, policies in many countries have changed to recognize the need for services to address young people's health and development needs, including SRH.

Why is the provision of specific services for young people so important?

Before exploring the types of services provided as part of the RHIYA programme, it is important to consider some of the contextual issues, and to ask and attempt to answer the following questions:

- Why do young people need adolescent SRH and HIV services, distinct from those of adults?
- In providing services for young people, is the environment enabling or constraining?

Stakeholder experience and baseline surveys provided a wealth of information to answer these questions, much of which mirrors the findings of earlier work conducted in this field⁹.

‘YOUNG PEOPLE FACE MANY RISKS’

In countries such as Bangladesh and Pakistan, cultural practices encourage early marriage. In other countries, rising levels of early premarital sex and childbearing increase the risk of maternal mortality and morbidity, and HIV infection. A number of factors were identified as putting young people at greater risk of poor SRH outcomes. Risks included a lack of education and life skills, poor access to health services and commodities, power dynamics especially when an older male partner is involved, sexual coercion and violence, trafficking, and growing up without parents or a stable family environment to protect young people from exploitation and abuse¹¹.

Project staff recognized that youth account for a growing proportion of the South and South-East Asia population and that they are a vulnerable group, in particular girls. The SRH risks facing a growing cohort of young people have implications for both the future health of the population and the countries’ economic and social growth. For instance, in Nepal, of its approximate population of 24 million people, 8 million are aged 10-24.

‘YOUNG PEOPLE LACK THE ABILITY TO ACCESS SEXUAL AND REPRODUCTIVE HEALTH SERVICES’

While knowledge of FP and HIV/AIDS is high among the general population within most RHIYA countries, SRH is a taboo subject. In most settings parents and teachers are reluctant to share SRH information or discuss SRH issues with young people. Young people not only have limited access to information to fill the gaps in their knowledge and clarify their misconceptions around the subject, but they also have limited access to commodities. For instance, results of a study in Viet Nam show a big gap between the high level of knowledge of HIV/AIDS and the low levels of condom use¹². Even if girls are married, they face difficulties in accessing services. In Bangladesh and Pakistan, where child marriage is common and early childbearing encouraged, girls have limited access to services specifically tailored to young people’s needs.

FP campaigns are most often targeted at married women. Few organizations are willing to accept responsibility for providing information and services to unmarried adolescents and youth¹³. In Sri Lanka, where young people are aware of family planning, services are not equipped to meet the needs of young unmarried people. In Viet Nam a study estimated the total unmet need for FP in the age group 15-19 is 10% and about 13% in the age group 20-24¹⁴. In Nepal, a total of 36% of adolescent women (15-19) have an unmet need for FP¹⁵. While there is a growing need for youth friendly services, availability remains limited, especially in government facilities.

⁹ Hardee K, Pine P, Taggart Wasson L, Adolescent and Youth Reproductive Health in the Asia and Near East Region Status, Issues, Policies, and Programs January 2004 Policy Project

¹⁰ UNFPA, Cultural Programming: Reproductive Health Challenges and Strategies in East and South-East Asia UNFPA Country Technical Services Team for East and South-East Asia, Bangkok, Thailand 2005

¹¹ Ross et al (2006) Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries, WHO





¹² Khuat Thu Hong PhD, Adolescent and Reproductive Health in Viet Nam. Status, policies, Programs, and Issues. Centre for Social Development Studies, January 2003 Policy Project

¹³ Lynnelyn D. Long, Le Ngoc Hung, Allison Truitt, Le Thi Phuong Mai, Dang Nguyen Anh. Changing Gender relations in Viet Nam's Post Doi Moi Era. June 2000 - Policy Research Report on Gender and Development. Working Paper Series No 14. WB, Development Research Group/ Poverty Reduction and Economic Management Network

¹⁴ Khuat Thu Hong PhD, January 2003

¹⁵ Adolescent and Youth Reproductive health, Nepal. Status, Issues, Policies and Programs. Ajit Pradhan and Molly Strachan, January 2003.

‘UNWANTED PREGNANCY AND ABORTION ARE DIFFICULT ISSUES TO ADDRESS’

Given the stigma associated with premarital sex, young people may be afraid to ask for contraceptives and may then try to seek abortions for unwanted pregnancies. Reports from Viet Nam suggest that abortions among unmarried women make up between 10% and 20% of all abortions in urban areas¹⁶. In a number of the RHIYA countries abortion is illegal, but even in countries where it is legal, access to safe abortion is limited for young unmarried people. In Cambodia, where abortion is permitted by law, a survey of health providers found that 59% of facilities did not admit patients younger than 18 years of age for post-abortion care. In addition, 42% of hospitals and 44% of health centres providing abortion services would not provide care to an adolescent. Only 3% of providers said they treated adolescents in the same manner as adult clients¹⁷.

In many cases, young people may not be aware that safe abortion services are available to them. In Nepal, the law guarantees every woman access to safe and affordable abortion services without discrimination. However, in 2004, only 42% of the urban public knew that abortion was legal (47% males and 37% females). Therefore, young women continue to resort to unsafe abortion¹⁸.

‘YOUNG PEOPLE ARE RELUCTANT TO SEEK SRH CARE’

Adolescents and youth are particularly sensitive to provider behaviours. Negative attitudes, refusal to provide care and/or a lack of confidentiality discourage young people from seeking care. Fear and embarrassment also prevent young people visiting health facilities and they often rely upon home remedies or visit traditional faith healers. The RHIYA baseline confirmed that pharmacies were the main source of information and services and that young people would only visit health posts, private clinics or hospitals when problems worsened or become unbearable¹⁹. This situation appears particularly acute among girls living in societies that restrict their movement or give greater value to boys, such as in Pakistan and Nepal.

“I have seen discrimination between boys and girls in various ways. If a son gets sick he is immediately taken to the hospital, but in the case of girls it is delayed. Boys are sent to boarding school whereas girls are sent to public schools. These attitudes are mainly prevalent among illiterate, poor and marginalized families”

(20 year old female,
Banke, Nepal)

In Nepal, the Public Health Concern Trust (PHECT) set up screening services for gender-based violence among young women as it was found that victims would rarely seek care. Further details of this service are contained within **You Are Welcome Here: Good Practices in Counselling & Clinical Services**, (RHIYA 2006).

Marginalized groups such as street children and commercial sex workers (CSWs) are often very reluctant to approach health service providers as they fear being scolded and turned away. This situation prompted the non-governmental organization (NGO) FRIENDS in Cambodia to set up services for street children and for CARE and the Women’s Union in Lao PDR to develop a referral network to increase provision of health services for CSWs.

¹⁶ Survey Assessment of Vietnamese Youth. MOH, General Statistics Office, UNICEF and WHO, August 2005

¹⁷ Rathavy, T. et al - Ready or Not? A National Needs Assessment of Abortion Services in Cambodia 2005 – IPAS

¹⁸ Adolescent Health and Development in Nepal. Status, Issues, Programmes and Challenges. Country Profile 2005. Ministry of Health and Population, Dept. of Health Services. Family Health Division.

¹⁹ Adolescent Health and Development in Nepal, 2005

‘YOUNG PEOPLE IN RURAL AREAS HAVE FEW CHOICES WHEN SEEKING SRH CARE’

Outside the major urban areas, access to SRH services for young people is particularly poor. The RHIYA baseline studies indicated that rural youth have less SRH knowledge and more limited access to services than urban youth. In the Lao PDR baseline, only 19.2% of rural youth were able to identify two modern contraceptive methods compared to 30% of urban youth. Similarly, only 24% of rural youth considered that contraceptives were easy to access, as opposed to 64.8% of urban youth²⁰.

However, the author would like to make a special note of the work that the RHIYA programme was able to put into practice among rural youth. As a result of the programme, the numbers of rural youth able to identify two modern contraceptive methods were shown to have increased at a much higher rate than those of urban youth, increasing to 58.8% of boys and 52% of girls (Lao PDR). However, differences between girls and boys within rural areas did persist at the RHIYA endline. The percentage of boys who felt that information on contraception was easily available was 48% as opposed to 39% of girls. Knowledge was also weaker among girls, with 55.7% of girls able to identify two methods of contraception compared to 62% of boys (Lao PDR). Thus, rural girls continue to make fewer gains in SRH knowledge than boys, which will also impact on their ability to access services.

‘POVERTY AND LACK OF EMPLOYMENT OPPORTUNITIES PUT YOUNG PEOPLE AT RISK’

Community leaders and parents stated that young people were at risk as they lacked job opportunities in their local areas. In Cambodia, migration to Phnom Penh for work in garment factories was identified as a risk factor, particularly for young girls. Poverty increases the likelihood of both boys and girls entering into commercial sex work. In many countries, the lack of employment opportunities for young men was seen as a risk factor in adopting unhealthy lifestyles such as alcohol and drug abuse. In Pakistan, parents and community leaders were concerned that this lack of employment opportunities could lead young men into crime or extremist activities.

‘EMPOWERING GIRLS IS NECESSARY IF SRH AMONG YOUNG PEOPLE IS TO IMPROVE’

Interviewees raised a number of issues which make girls more vulnerable to poor SRH:

- Generally men, rather than women, have control over SRH decision-making.
- Traditional stereotypes that encourage girls to show little knowledge of sexual matters hinder young women’s negotiations for safe sex with their boyfriends.
- In Viet Nam, it was found that young women are reluctant to use contraceptives, because not using any method of contraception is perceived as a sign of faithfulness and confidence that the relationship will lead to marriage²¹.
- Married adolescents do not use contraception, because of pressure to start childbearing early. In Nepal, less than 5% of married adolescents were using condoms and only 3.7% were using injectables (MOH 2002)²².
- If there is a significant age gap between a girl and her partner, this creates a power dynamic in which the girl is less able to negotiate contraceptive use or safe sex.

The opinions expressed by the stakeholders, and the supporting evidence from studies, clearly point to the fact the young people’s needs are complex and that improving their SRH will require a diverse range of services. Senderowitz (2000) states that services should be provided in diverse ways and settings, as young people’s needs and preferences for services vary considerably, especially at different ages and stages of development. In an ideal setting, choices should be available for counselling as well as preventative care and treatment options. Adolescent and youth services (such as youth corners and centres, clinical and counselling services) may go some way to reducing girls’ increased vulnerability to the consequences of gender inequity and inequality, provided that services are tailored to their needs. Non-judgemental provider attitudes, trust, confidentiality, affordable cost, convenience and confidence in the quality of care are all essential elements of youth friendly services.

²⁰ All RHIYA baseline and endline information has been cited from the Country Final Reports, RHIYA Monitoring and Evaluation (UCL 2007)

²¹ Long, L. D, Le Ngoc Hung, Truitt, A, Le Thi Phuong Mai, Dang Nguyen Anh. Policy research Report on Gender and Development. Working Paper Series No 14. Changing Gender relations in Viet Nam’s Post Doi Moi Era. June 2000 The WB, Development research group/ Poverty Reduction and Economic Management Network

²² Adolescent Health and Development in Nepal. Status, Issues, Programmes and Challenges. A Country Profile 2005. Ministry of Health and Population, Dept. of Health Services. Family Health Division

Constraining or enabling environments for service provision – RHIYA experience

While there is a clear identified need for a diverse range of services for young people, many of the stakeholders – both youth and project staff – emphasized the need for advocacy efforts at all levels due to the sensitive nature of the issue:

- **At policy level** – lack of, or restrictive, government policies fail to prioritize or facilitate services for young people. SRH for young people is a sensitive political and social issue, therefore government ministries and departments are often unwilling to risk prioritizing provision of services, especially when they continue to struggle to provide quality SRH services for adults.
- **At family and community level** – SRH for young people is a taboo subject. Often adults are reluctant to support SRH service provision for young people. Furthermore, SRH in general is not considered a priority in communities where poverty, water and sanitation, and employment opportunities are more pressing concerns.

The report **Peer Education – A Review of Stakeholder Experiences** (RHIYA, 2007) focused on the extensive advocacy efforts carried out at all levels of the RHIYA programme in order to encourage the acceptance of youth programming. NGOs also played an important role in increasing access to services for young people by supporting changes in the SRH policy environment and in helping develop service initiatives based on new policy.

POLICY ENVIRONMENT

As previously stated, laws and policies related to youth SRH are often restrictive (Nelson 2000) and involvement of young people in policy formulation is globally low. Policymakers are often poorly informed about the needs of young people and the consequences of not providing adolescent and youth SRH services. In addition, the multisectoral approaches to young people's services make it more difficult to move forward, as often mechanisms for cross ministry or interdepartmental working are not clearly laid out and fail to facilitate partnership approaches.

The UPSUs and implementing partners in RHIYA countries played a role in facilitating changes in adolescent and youth policies; and in supporting innovative service models, which resulted in an environment where the provision of services for young people was possible. Overleaf are country-specific summaries of the changes in youth policies that have been made over recent years. In some instances, the changes were made before the RHIYA programme; in others the programme had a more direct influence. In many cases, RHIYA led the way in implementing programmes based on the new policies.





BANGLADESH

- There is an overall supportive policy and legal environment in favour of adolescent SRH, but laws and policies have not been enforced.
- The Population Policy 2004, the National Strategic Plan for HIV/AIDS 2004-2010 and the Youth Policy 2003 address youth and gender issues and present strategy guidelines for the provision of information, counselling and youth friendly services.
- Guidelines for adolescent friendly services have been developed by Ministry of Health and Family Welfare (MOHFW) and distributed to government health workers, but with insufficient accompanying training and support.
- Adolescent SRH (ASRH) is included in the school 10th grade curriculum, but is usually avoided by teachers or addressed in a very scientific way that does not address behavioural issues.
- The RHIYA youth resource centres helped to approach SRH in a more imaginative manner, by providing reading materials and a comfortable environment. RHIYA has participated in the development of the MOHFW Adolescent SRH strategy, which mirrors the RHIYA approach.
- The MOHFW is aware of its own limitations and the important role played by NGOs in ASRH service provision.
- RHIYA was closely linked with the 7th UNFPA Country Programme, which identified ASRH as a specific programme area.
- Few organizations other than RHIYA implementing partners were working in this field.

LAO PDR

- The Lao PDR Government is committed to the ICPD Programme of Action.
- The government has two main policies on ASRH: the National Reproductive Health Policy, which includes a section on youth, and the National Population and Development Policy, which is being updated to include a stronger focus on the SRH needs of youth.
- ASRH is included in the 2nd UNFPA Country Programme, 2002-2006, which notes that: "RHIYA is a special programme, which for the first time has introduced country interlinkages and collaboration among various international NGOs in ARH".
- Through the innovative work and support of the RHIYA programme, ASRH will be a priority area in the 3rd UNFPA Country Programme, 2007-2011.

PAKISTAN²³

- At national level, Adolescent RH (ARH) is a neglected area with no government policy for provision of IEC or services for young people.
- RHIYA and UNFPA have made important inputs into the draft Youth Policy, which now includes ARH. However, at the time of this report the policy had not yet been submitted for Cabinet approval and is only directed at age 18-30.
- ARH is a politically sensitive area, which the government is reluctant to address, preferring to leave pioneering work to NGOs.
- In practice RHIYA has found it easier to coordinate effectively at district government level, as local leaders are more aware of the RH issues of young people in their areas.
- RHIYA approaches are coherent with the European Commission's current country strategy and with the 2007-2013 UNFPA programme that will focus on education and rural development, either of which could incorporate aspects of RHIYA approaches.
- The priority geographical areas for the 2007-2013 programme are also compatible with several of the zones in which RHIYA operated.

CAMBODIA

- The RHIYA project ensured coherency between the country situation, national plans, and the UNFPA and EC programmes, by including all key agencies on the project's Advisory Group.
- The Secretary of State of the Ministry of Health (MOH) was very supportive of RHIYA, which had a significant influence on shaping government ASRH policy in Cambodia, including the SRH Strategy and Strategic Plan, 2006-2010 and the National Guidelines for Adolescent Friendly SRH in Cambodia (both approved in March 2006).
- The MOH is committed to supporting NGO activity in addressing ASRH issues and has provided training for peer educators in some NGOs through the Department of Maternal and Child Health (MCH).
- RHIYA NGOs have had the opportunity to meet with senior health officials through the Advisory Group Meetings.
- A multisectoral approach to ASRH has been adopted by the government and the MOH liaises closely with the Ministry of Education, Ministry of Women's Affairs, Ministry of Social Affairs, and the National AIDS Authority.

²³ In Pakistan reference is made to Reproductive Health (RH) and not Sexual Reproductive Health (SRH)

NEPAL

- The Government's 2nd Health Plan 1997-2017 includes ASRH, which is considered a critical component of reproductive health. The plan endorses distribution of contraceptives to unmarried adolescents.
- The National Adolescent Health and Development Strategy (2000) refers to gender issues and the complementary role of NGOs in ASRH programmes.
- The new ASRH school curriculum includes the majority of themes that were included in RHIYA's educational component.
- There is a UN joint initiative against trafficking in girls and women, as well as UNFPA's current five year Country Programme (2002-2006) whose SRH sub-programme includes support for adolescent services in government facilities and gender-related issues.
- Most donor and some NGO programmes are now coordinated through a sector wide approach (SWAp).
- RHIYA's programme design and interventions targeting rural youth through community-based approaches were influenced by the European Commission's Country Strategic Paper for the period 2002-2006, which focused on rural development among other factors.

SRI LANKA

- The National Population and Reproductive Health Policy of 1998 only includes provision of FP counselling for married young people.
- The new ASRH policy which is currently being developed by the MOH with support from UNFPA has a stronger rights-based approach and more focus on provision of services; this has been facilitated by the RHIYA NGO experiences.
- MOH has recently curtailed the registration of marital status of service users, thus opening the door to provision of family planning methods to unmarried young people. In practice this will take some time, as service provider bias will have to be overcome.
- RHIYA is aligned with the new UNFPA country programme (2007-2013) which will focus on ASRH, HIV/AIDS prevention for out of school youth (being carried out under a joint initiative with UNAIDS) and quality of care.

VIET NAM

- A supportive legal and policy framework already exists in Viet Nam. However, poorly trained health staff and a lack of financial resources means that adherence to, and implementation of, these policies is inadequate.
- The Youth Health Master Plan developed by WHO with the MOH specifically includes HIV, SRH, mental health, substance abuse and it considers adolescent targets.
- The National Action Plan of UNFPA (2006-2010) also supports ASRH provision. Furthermore, the SRH issue has been included in the Youth Law, which is currently in development and a decree was to be signed in July 2007. Following the approval of this important document, it is likely that all Youth Union members (estimated at over one million young people) will be sensitized to ASRH.
- The RHIYA programme has pioneered new ASRH projects and strategies. A unique feature of RHIYA in Viet Nam has been the very careful design of the partnerships and interrelations between the executing and implementing agencies, the supporting organizations and institutions.
- The very high level of participation from partners and authorities within this complex structure will result in a long-term impact. Behaviour change communication (BCC) strategies, guidelines and ASRH media-focused plans already provide the basis for long-term BCC and will greatly influence a broader vision among national institutions.

19 Group Discussion, Advocacy workshop, Hanoi, Viet Nam



The RHIYA programme has advocated for an enabling policy environment and has assisted governments to implement policy changes through its services – often by experimenting with innovative service provision models and modalities. In many countries, the RHIYA programme has been a catalyst for change. The different examples of models and modalities in RHIYA service provision will be addressed in detail in the following sections.



A Place of Our Own:

Different models and modalities
in services for young people



Services for young people – different models and modalities

Over recent years, the youth agenda has broadened to include a wider, social development agenda with an emphasis on vocational needs, which resonates with adolescents and young people in low income countries. A broad-gauged social development agenda for adolescents has been endorsed by UNFPA, WHO, UNICEF, UNIFEM and many private foundations. There is increasing emphasis on meeting the needs of more vulnerable and hard to reach subsets of young people through non-health interventions such as education, and combining social protection and livelihoods programmes for out of school youth²⁴. Although the RHIYA programme outcomes focused on SRH issues for young people, many of the RHIYA projects were designed and/or adapted by the various NGOs to address these broader social development and vocational issues; and to focus on a holistic, integrated and mutually reinforcing package of interventions.

Intervention areas included:

- Facilitating an enabling environment through advocacy and interaction with policymakers, community leaders and families.
- Supporting improvements in knowledge and bringing about changes in attitudes and self-efficacy through peer education, life skills training, mass media and community interventions.
- Providing services for young people including social, vocational and preventative health services delivered in many different settings to diverse target groups.

This broad approach has led to different services with different nomenclatures across countries and between projects (see table Overview of services for young people provided under the RHIYA programme). While the endline reports demonstrate that RHIYA successfully met the needs of young people and brought about changes in knowledge, attitudes and behaviours, actually attributing the success to a specific activity is very difficult (see **Catalysts for Change – A Synthesis of RHIYA’s Achievements**, due October 2007).



SERVICE	COUNTRY	ACTIVITIES
Meeting information, social and vocational needs		
Youth corners	Pakistan, Lao PDR, Viet Nam	IEC materials and/or general reading material
Service delivery points	Sri Lanka	Information and counselling services, condom distribution
Youth resource centres	Bangladesh, Cambodia	IEC, general reading, TV, drama, counselling
Youth centres	Lao PDR	IEC, sports, social activities
Youth friendly centres (multifunctional)	Pakistan	IEC, counselling, games, sports, debates, vocational training activities – computing, English courses, cookery courses etc
Youth information centres ²⁵	Nepal	IEC, peer education, games, condom box, question/letter box, staff education sessions, income generation and saving schemes and sometimes outreach clinics
Meeting SRH needs		
Youth friendly corners ²⁶	Viet Nam	IEC, counselling, FP, STI testing, menstrual regulation, referral and outreach activities and BCC sessions
Youth friendly service delivery points or youth friendly service centres ²⁷	Nepal	IEC, counselling, vaccinations, contraceptives, medical check-up, referral (sub-health posts) IEC, counselling, FP, STI testing and treatment, VCT, referral, abortion, abortion after care, safe motherhood, ANC/PNC, immunization, counselling on gender-based violence, drug abuse and injuries (NGO clinics)
Youth SRH clinic and mobile clinic services	Cambodia, Lao PDR, Bangladesh	IEC, counselling, FP, STI testing and treatment, VCT, referral, crafts, computer courses, English courses (NGO clinic in Cambodia) IEC, counselling, FP, syndromic management of STI, and referral (Lao PDR only)

²⁴ Bruce, J. Chong, E. The Diverse Universe of Adolescents, and the Girls and Boys Left Behind: A Note on Research, Programme and Policy Priorities, Millennium Project 2005.

²⁵ The 92 YICs, established in a variety of locations, are spaces where youth can meet with peers, play games and sometimes they are used as outreach clinics. YICs are the focal points for peer educators' activities.

²⁶ RHIYA Viet Nam established 22 YFCs in existing MOH facilities.

²⁷ A total of 55 YFDSPs have been set up, located in existing MOH facilities (30), NGOs (20) and in the private sector (5). In some locations the YICs and YFDSPs were established in the same building.



We Need to Know:

Meeting information needs
in youth corners







KEY POINTS COVERED IN THIS SECTION:

- Youth corners are a useful way to link health and education activities – increasing SRH information for in school youth.
- In order to ensure maximum utilization, there should be careful assessment of the need for youth corners, their location and content.

Meeting information needs: youth corners

“I went on a study tour
of RHIYA projects in other
countries and
saw youth corners
working very well”
(Lao PDR)

Youth corners provide young people with information related to SRH, in addition to other more general subjects. The aim of youth corners is to provide a place where adolescents and youth can find information, sit and browse through literature/materials in their own time. On the whole, youth corners or information centres are set up in facilities used for other purposes, such as schools to target in school youth or in SRH clinic settings targeting both in school and out of school youth. Often RHIYA youth corners were established after project staff had seen the approach work well in other RHIYA projects or because local teachers identified their difficulty in approaching SRH subjects. In Viet Nam, a specific needs assessment process was conducted to establish whether or not youth corners would meet youth information needs. The endline results suggest this was a good approach, with 89% of youth stating that access to contraceptive methods was easy as opposed to 64% at the baseline.

Again it is difficult to attribute these improvements solely to the existence of youth corners, however in school youth particularly mentioned that youth corners were important sources of information while out of school youth made considerable use of the youth information centres – especially because of the ‘drop-in’ nature of services, such as those in Nepal. The Nepal endline demonstrated that 84.4% of youth thought information on contraception was easy to find, showing a positive increase from 65.5% at the baseline.

There is a growing body of knowledge around youth corners that have been successfully implemented in a number of settings. The box ‘Implementing youth corners worldwide’ highlights examples taken from other (non-RHIYA) projects to demonstrate how they were implemented – a number of these programmes linked youth corner activities with the work of peer educators, and catered for in school and out of school youth.

IMPLEMENTING YOUTH CORNERS WORLDWIDE

- In Zimbabwe, the Family Planning Service Expansion and Technical Support Project (SEATS) collaborated with the Gweru City Council to establish youth corners at adult clinics. These spaces were located away from the busiest parts of the clinic to give young people a private place to talk with peer educators and to read information materials. Peer educators could refer young people who wanted clinical services to nurses who were specially trained in youth friendly services²⁸.
- The Geração Biz programme in Mozambique was selected as a best practice under the World Bank Initiative on Education and HIV/AIDS. With support from UNFPA and Pathfinder International, the programme has trained 3,000 peer educators, established “youth corners” in 27 schools and 14 communities, developed two videos for youth and, in 2003, distributed 230,000 condoms during 50,000 client visits at 32 sites offering youth friendly health services²⁹.
- In Egypt, the establishment of 24 Adolescent Information Corners (AICs) in schools, youth clubs and clinics has greatly improved adolescents’ knowledge of SRH issues, which were taboo subjects in Egypt until recently. Here young people have access to a wide range of audio-visual and printed materials on topics related to ASRH. They are breaking the silence on ASRH. Interest among young people in these subjects is growing by the week; thousands of young people have visited the AICs or met with local peer educators³⁰.





²⁸ <http://www.jsi.com/JSIInternet/Projects/ListProjects.cfm?Select=Country&ID=430>

²⁹ http://www.pathfind.org/site/PageServer?pagename=Programs_Mozambique_Projects_GeracaoBiz

³⁰ http://www.unfpa.org/daseca/projects/proj_egypt_corners.html This initiative is being implemented by UNFPA and the Egyptian Family Planning and Reproductive Health Association (EFPRHA, the national International Planned Parenthood Federation affiliate).

Establishing youth corners

The youth corners established under the RHIYA programme differed depending on the resources available. If resources were limited, the corners included a small space with tables, shelves and chairs, notice boards, leaflets, posters and reading materials. Where resources were sufficient, TV, video equipment and even computers were supplied. The youth corners were mainly situated in part of an SRH clinic or in schools. Below are a number of examples from the various countries outlining how the youth corners were established, and what seemed to work well and not so well.



| 15 Female friendly corner, Kohat, Pakistan

PAKISTAN: YOUTH CORNERS A REAL BREAKTHROUGH

In Pakistan, the implementation of youth corners in schools was a relatively new approach at the time of visit and therefore no outcome data was available. In Jacobabad and Qila Saifullah districts, Balochistan, the implementing partner District Coordinators introduced the concept of youth corners less than 12 months before the end of the project. The project staff stated that it had proved an important step forward for the project, as it established links with schools. Teachers were trained and given some financial incentive to cover the time spent setting up and maintaining the corners. It was evident that teachers were enthusiastic about the approach and had maintained the corners with updated literature. The schoolchildren used the corners often.

The youth corners in Pakistan were considered a success for two reasons. Firstly, to establish them in such a conservative environment is an achievement in itself. Secondly, the youth corners served both girls and boys who had limited access to outside information as they lived in the Madrassah (Islamic religious school) away from their families and communities.

- In Jacobabad, youth corners have been established in schools. One teacher from each school, together with the peer educators, has been trained in the use of the IEC materials. The teacher and peer educators then worked together to set up and maintain the corner. Sometimes the schools had been able to provide a room; in other schools, corners were in a classroom or part of the library.
- In Qila Saifullah, the youth corners have been introduced into four Madrassahs and two were established in Muzaffarabad. Some of the Madrassahs were careful to keep this innovation low key and had asked visiting project staff to use unmarked cars. The teachers were very enthusiastic, but have needed to ensure the administrators reviewed and approved the materials before they were put on display. In one Madrassah, only general health information was approved, but project staff felt that as trust was further established they would be able to include RH information.
- In addition, a number of government school corners had been established in Qila Saifullah and Muzaffarabad. These were popular with teachers and children alike. Setting up these corners did not require a great deal of advocacy, as other project activities were already well established and the community trusted the NGOs and their motives. Advocacy efforts are fully explored in **Peer Education – A Review of Stakeholder Experiences** (RHIYA 2007).

YOUTH CORNERS ASSISTED IN DELIVERING THE CURRICULUM

In Viet Nam, the Advocacy and Behaviour Change Communication Output Project established school information corners in 20 high schools and universities with peer educators (14-17 years of age). Peer education activities formed an integral part of the extra-curricular activities and were allocated 45 minutes of the school timetable per week. The combined school information corner and peer education strategy was welcomed as a social activity, as it fitted well in the extra-curricular annual plan, and the corners were well utilized by schoolchildren, both girls and boys. In addition, youth friendly corners (YFCs) were established alongside youth friendly health services in static clinics. This approach combined access to information and provision of clinical services and is highlighted in the **RHIYA Good Practices Guide**³¹.

INFORMATION, INFORMATION, INFORMATION

In Bangladesh, the lack of opportunities to discuss SRH issues with parents and to access information was a significant problem. Given the taboos associated with discussing SRH, youth were very pleased to have had the opportunity to talk through issues. In addition, the youth corners/resource centres within NGO clinics provided a much needed meeting point, where youth 'felt safe' to come and talk, read materials and watch television. The RHIYA baseline survey found that, in the age group 10-14, 54% of adolescents perceived it as easy, or very easy, to find family planning information; this increased to 86% in the endline survey, with findings similar for both girls and boys.

LOCATION, LOCATION, LOCATION

In Lao PDR, the Vientiane Youth Centre established youth friendly information boards in a number of villages around the capital. These boards were often located near, or in, houses and offices of the village authorities and were not well used as a result. This approach is now being reviewed. One of the staff members felt that the reason these corners were underutilized was that local authority offices were not appropriate or 'natural' places for young people to congregate. While the location may not have been well chosen, there is still an obvious need for more sources of information. The endline results from Vientiane found that the percentage of young people who felt that contraception information was easily available in urban areas was relatively low (71.5% of boys and 58.5% of girls). However, this may in part be due to the fact that youth within an urban setting are more mobile and may have moved on before the endline survey was conducted.



16 Peer educators coming into Vientiane Youth Centre from the street, Lao PDR

³¹ Case Studies from RHIYA: Good Practices in Clinical Services & Comprehensive Programmes
EU/UNFPA Reproductive Health Initiative for Youth in Asia (RHIYA) 2006: The Power of Synergy: Collaborating to Address Young People's SRH in Viet Nam





Monitoring youth corners _____

Monitoring the outcomes of youth corners is quite challenging. The monitoring framework set up for RHIYA youth corners covered the numbers of corners established, numbers of teachers trained and number of youth using the corners; rather than attempting to measure the outcome of these services in terms of knowledge gained. However, the endline surveys from across the RHIYA programme showed a positive gain in terms of both young people's perceived ease in accessing SRH information and also in relation to their SRH knowledge.

Client exit interviews were conducted across all the countries to measure the quality of information. In some projects, mystery clients were employed to measure quality of services and the levels of satisfaction among service users. Although surveys were carried out comprehensively and systematically, results of client exit interviews were almost universally positive. This limited the scope to gauge improvements and may point to a need to find more sensitive monitoring tools. A more systematic use of mystery clients might improve the programme's qualitative information. In addition, the programme could develop quality criteria for monitoring purposes with the youth themselves, for instance through focus group discussions, these criteria could be used by the staff and young people to assess services.

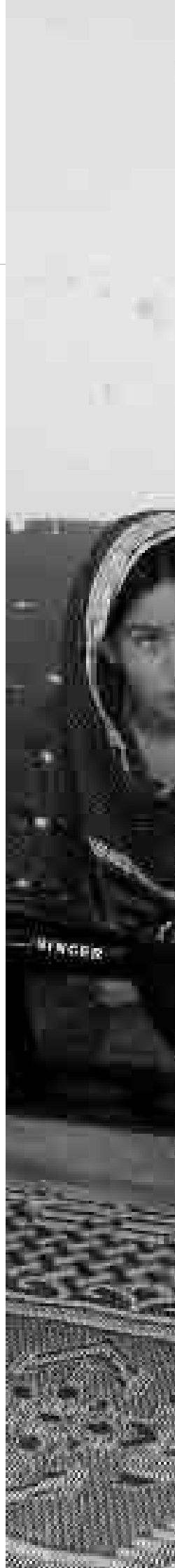
When interviewed, young people who had used youth corners felt they were 'good spaces' to spend time, relax and they stated that the information was useful and up to date. One young man did feel that the choice of information could be broadened to include more general reading material – as once he had read the SRH materials he did not need to keep returning to them, but he did enjoy reading current affairs, newspapers and journals. When youth were made responsible for choosing and updating the corner's materials, they were more relevant.

Facilitating factors – as stated by stakeholders

- Teachers and health staff were convinced of the need for young people to have access to written materials and information. Often the materials available to teachers were limited to the HIV/AIDS information provided as part of the national curriculum, as in the case of Viet Nam. Previously more general SRH information was rarely available, such as materials on changes in puberty and menstrual issues.
- Youth corners provided an informal area where young people could choose to access information in their own time by just 'dropping in'.
- The projects ensured that the teachers' and peer educators' interest in maintaining the youth corners were reinforced by providing training, materials and support.
- In Viet Nam, it was recognized early in the programme that it would add value if two executing agencies combined their respective interventions (BCC and supply of services) within the same project site. Combining interventions facilitated youth to access both information (through the youth corners) and services (through the youth friendly health services). This was only made possible in Hanoi, Ho Chi Minh City and Hoa Binh Province. However, other areas established local-level information sharing networks to ensure close collaboration between the local Youth Union and YFCs.
- Advocacy efforts by the programme staff, alongside other successful interventions, paved the way for youth corners. For instance, the youth corners in Pakistan were implemented later in the programme following successful advocacy efforts to ensure they were accepted and supported by community leaders, teachers and parents. Advocacy efforts addressed many issues such as gaining community approval for establishing YFCs – various approaches were taken, including one to one meetings with political, community and religious leaders. The advocacy efforts of the RHIYA programme are expanded upon in **Peer Education – A Review of Stakeholder Experiences** (RHIYA 2007) and **Opening the Doors of the Corridors of Power – Good Practices in Advocating for Policy Development** (RHIYA 2006).
- Youth corners in schools provided an excellent way of linking with education departments and helping to advocate for the provision of more SRH information in schools.

CONSTRAINTS AND CHALLENGES

- A lack of systematic needs assessments meant that some youth corners were not located in places that young people could easily access—this led Lao PDR to review the location of youth corners.
- Youth corners tended not to be used by the most vulnerable out of school youth; as they were often located in more formal settings, such as schools or SRH clinics. In Nepal, however, the informal 'drop-in' centre approach encouraged more vulnerable youth, such as those involved in drug use, to access information.
- While parents were often happy for HIV/AIDS information to be included in the youth corners, they were less sure about information related to SRH, such as contraception, as they felt this would encourage youth to explore their sexuality too early.
- Sustaining the youth corners was an issue, with many of the school information corners closing at the same time as the project (Viet Nam).
- Conservative school authorities restricted the RH materials available in the youth corners (Pakistan).





GETTING IT RIGHT – KEY FACTORS FOR ESTABLISHING YOUTH CORNERS

From RHIYA programme experience, a number of factors appear to be important when establishing youth corners:

- Youth corners should be in easily accessible places where young people are more likely to congregate e.g. schools and libraries are popular locations.
- Teachers and peer educators should be trained to establish and maintain youth corners, but this requires regular support to ensure the corner remains relevant and they have access to new information.
- SRH information should be updated regularly – perhaps providing themed information; addressing different topics on a weekly basis such as friendship, negotiating safe sex, loving relationships etc.
- Topics of general interest to young people (career information, newspapers and magazines) help to maintain interest in the corner.
- Monitoring should include the opportunity for young people to establish quality criteria for the corner, in addition to commenting on the usefulness of the information available.
- Whenever possible young people should be involved in the design of the youth corner and be responsible for its maintenance.



Somewhere to Go and Something to Do:

Meeting social and vocational
needs in youth centres







KEY POINTS COVERED IN THIS SECTION:

- Social and vocational activities meet the broader development needs of young people, while continuing to provide an entry point into SRH information and counselling services.
- Social and vocational activities appeared to support girls' participation and empowerment.
- Validating training courses to help increase employment opportunities for young people should be explored further.
- Vocational training courses should be considered – to avoid reinforcing gender stereotypical employment options and to explore more innovative training opportunities.
- Youth centres are resource intensive and may suffer from sustainability issues. In some areas, youth centres became the focus of a number of wider community activities; this ensured that communities were more likely to support sustainability efforts.
- Monitoring and review frameworks for youth centres need to be strengthened in order to better identify outcomes.

Meeting social and vocational needs – youth centres

Youth centres were established to complement a comprehensive programming approach, which included peer education, mass media, youth corners and clinical health service provision. Youth centres aimed to meet the development needs of young people in a holistic way – providing a safe space where young people could meet friends, play sport, socialize, obtain SRH information, and build social and vocational skills.

In two RHIYA countries, clinical service provision for youth was not provided. Youth centres in these contexts were important in providing information, counselling and referral, and in some instances for condom distribution.

- In Sri Lanka, the RHIYA projects did not incorporate youth friendly health service provision to ensure they were in line with the National Population and Reproductive Health Policy of 1998³², which only included the provision of information and counselling services for unmarried youth.
- In Pakistan, the implementing NGOs did not provide clinical services under the RHIYA programme, as the UNFPA programme were developing the basic health units in the RHIYA programme areas.

Across the RHIYA programme, youth centres had different nomenclatures including: youth information centres, youth friendly centres and youth resource centres. For the sake of convenience, the term ‘youth centres’ is used in this paper as a collective term. Youth centre services included IEC and different interactive social/education activities such as drama, quizzes and debates, sports, vocational activities and condom distribution. Often the centres’ activities extended to the wider community through various events, for example religious and national holidays, and UN special days.

While the youth centres provided a range of services, the focus was primarily on ensuring young people’s increased access to SRH messages. A recent WHO review of interventions to help prevent HIV/AIDS infections in young people (2006) identified a sufficiently strong evidence base to support the continued delivery of interventions targeting both adults and youth when they are delivered through traditional or family networks; or when they are delivered through community-wide events such as theatre, health fairs, festivals and competitions.

³² This policy did not include provision for clinical services



Addressing young people's needs

A number of youth centres were set up in response to problems and issues identified in research studies. For example, in Pakistan, the RHIYA implementing NGOs based their programmes on the nationally representative survey of adolescents and youth conducted 2001-2002³³. This survey highlighted the lack of RH knowledge among youth and the paucity of information regarding youth sexual behaviour. In addition, it drew attention to the large gender gap between girls and boys in Pakistan, particularly in poorer areas of the country.

RISKS AND ISSUES FACING YOUTH IN PAKISTAN

During the stakeholder interviews, RHIYA project staff and parents highlighted the potential risks and issues affecting young people in Pakistan today, these included:

- Lack of recreational activities for young people, especially girls.
- Lack of job opportunities – high unemployment.
- Low levels of literacy, especially among girls.
- Lack of opportunities for youth to mix and to gain understanding of the other sex before marriage.
- Lack of dialogue between parents and children, especially about RH.
- Girls tend to rely on information from their mothers, often they are illiterate and reluctant to enter into conversations on such matters.
- Lack of education and social contact for girls, which increases their vulnerability to poor RH and gender-based violence.
- Boys (about 60%) rely on their peers for information.
- Boys are at risk from illegal drug use, joining criminal gangs and participating in extremist activities.

In Lao PDR, a participatory action research was undertaken during 1997 and 1998 by the Vientiane Municipal Women's Union and Save the Children, UK. The 'Listening to the Voice of Young People' project highlighted young people's thoughts, feelings about life and their aspirations in Vientiane. Through this it became evident that young urban people are at high risk of HIV, due in large part to their lack of life skills and their poor understanding of HIV/AIDS prevention strategies. The Vientiane Youth Centre for Health and Development project was initiated largely as a direct result of this research. The Centre provides a safe place for youth to meet, talk, play and interact. Since its inception, a clinic has also been opened in the same grounds; this is reviewed later in the section Our Health Matters.

³³ Adolescents and Youth in Pakistan 2001-02 – A Nationally Representative Survey, Population Council and UNICEF.

Services provided – social activities and vocational training

A common criticism of the RHIYA programme by community leaders was that youth needed jobs more than they needed SRH knowledge. In response, the projects successfully combined social and vocational activities and SRH information, which was an important element in creating an enabling environment. Social activities and vocational training provided a more holistic approach to youth needs, particularly in countries such as Pakistan where youth – especially girls – had few recreational opportunities. In addition, in areas where opposition to youth SRH information and knowledge was strong, the youth centres helped to build community confidence in the projects and acted as an entry point for introducing SRH. In Pakistan, the YFCs provided a wide range of activities as illustrated in the table below:

YFC ACTIVITIES IN PAKISTAN	
Area	Activity
Sports	<ul style="list-style-type: none"> • More indoor sports for girls – board games etc • Outdoor activities for boys, e.g. cricket • Competitions for boys and girls to support team building skills and self esteem
Recreational and livelihood training	<ul style="list-style-type: none"> • Both sexes now have access to computer training. The introduction of computers saw a sharp increase in the numbers of youth using these facilities. Boys have been allowed to teach the girls computer skills. • Other activities include craft making, embroidery, cooking classes, English lessons, beautician courses etc.
Platform for youth education and entertainment	<ul style="list-style-type: none"> • Debates, drama, RH education, counselling including premarital counselling. • Often establishing RH has been through health education in the first instance e.g. hygiene or Hepatitis B, which is an acknowledged issue in many communities. • Other activities include the youth camps, which provide an opportunity for youth from around the country to meet and discuss relevant issues.



Who Used the Centres?

Bruce and Chong (2005) suggest that in many circumstances more boys than girls use youth centres. Research in Kenya on two centres showed female attendance was low, especially for SRH services. Males outnumbered females by 2:1 and the vast majority attended the centres for recreational activities³⁴. Similar results were found in Zimbabwe and Ghana. However, due to the substantial effort of the project staff, this does not seem to have been the case across the RHIYA countries. In Pakistan, Nepal and Bangladesh, efforts focused on ensuring that girls had equal access to the centres; including equal participation and involvement in decisions made on the running of the centres. While interaction between boys and girls was monitored, it was not deemed necessary to create 'girls only' sessions in the mixed youth clubs; as the project staff felt the youth interacted well together and it was important for them to mix in order to increase understanding between the two groups.

Project staff clearly recognized that just setting up services did not guarantee that youth would use them; it was also important to appeal to youth's broader interests. In Pakistan, a number of staff at different sites pointed out that YFC utilization rates for both girls and boys increased dramatically when computer courses were introduced. In Nepal, sports materials and daily newspapers in YICs attracted young people. They read IEC materials, organized group interactions on SRH and discussed various educational activities. In Bangladesh, the youth resource centres provided opportunities to develop debates and drama, most of the peer educators and many peers were involved in these activities. These social activities were used as a medium for conveying the SRH messages; the use of drama was a particularly powerful way to engage with youth and also with parents. In Sri Lanka, drama was successfully used in the tea plantations to engage the community as a whole.

In Pakistan, one youth centre visited in Balochistan, as part of the stakeholder review appeared to have become a meeting point for all ages. During the visit, peer educator training for young women was being conducted in one room, while in another a craft class was underway for older women, and in another a reading class was being held for small children – some of whom were the children of the women in the craft class. Conversations with project staff confirmed that this was not unusual and that many of the youth centres doubled as community centres. While this has implications in terms of the young people not having a space of their own, it did appear to help in terms of sustainability – with the communities actively involved in ensuring funding to continue the centre after the project ended.

³⁴ Erulkar, A. A. Mensch, B. S. Youth Centres in Kenya: Review of the Family Planning Association of Kenya Programmes, Population Council, Nairobi, October 1997.



Location

SERVICE LOCATION	COUNTRY	DESCRIPTION
Dedicated buildings established by the RHIYA programme	Pakistan	All 80 youth friendly centres were adapted to the needs of young people, and often included an outside recreational area. They were situated in both rural and urban areas.
	Lao PDR	The Vientiane Youth Centre is situated in a convenient and central location, easily accessible to young people.
Youth centres situated in the NGO SRH clinics	Cambodia	The youth resource centres were developed in existing SRH clinics, but clearly a lot of thought had been put into adapting the facility to the needs of youth, including a separate entrance in the RHAC clinic in Phnom Penh, which was also used by young people to access clinic services.
	Bangladesh	A separate building had been erected at the side of the SRH clinic, e.g. in the Family Planning Association of Bangladesh (FPAB) centre in Cox's Bazaar.
Situated within other non-RHIYA services	Nepal	Some YICs were in the same buildings as the YFCs, in other areas they were established in the villages, separate from the clinical services. For the most part, the facilities were simple, but decorated with posters and made to feel welcoming. If the health facilities could not provide privacy, the YICs, were often used for counselling purposes.

A lot of thought had gone into decisions about the physical infrastructure of the youth centres, however, it is not easy to determine which of these settings is the most conducive to meeting the needs of young people.

MAKING YOUTH CENTRES YOUTH FRIENDLY

Stakeholders identified a number of elements which helped to make youth centres more 'youth friendly':

- Welcoming environment – bright colours, colourful and clean, pictures of activities on the walls.
- Convenient location.
- Convenient opening times – the youth centres were open on Sundays in Nepal.
- Adequate space for recreational and vocational activities and counselling.
- Adequate places for private conversations.
- Sitting areas with comfortable seating.
- Educational activities designed for youth, including games, TV and video.
- Refreshments available.
- Condom boxes (in some facilities).
- Suggestion boxes.

Young people stated how much they liked the spaces, especially when they were involved in creating them. Often the projects encouraged the young people to create the space themselves and to decorate it as they wanted; this made them feel very welcoming and added to the feeling that it was their space.

Outcomes

HELPING ADVOCATE FOR THE INCLUSION OF SRH INFORMATION

Youth centres aimed to positively impact on youth SRH knowledge and on the attitudes of both young people and communities. People of all ages clearly appreciated the drama productions and other such events. These positively raised the profile of the centres and assisted in gaining acceptance of SRH topics for young people within the communities.

INCREASING UTILIZATION OF YOUTH CENTRE SERVICES

Youth centres experimented with different approaches to encourage youth participation. Attendance figures clearly demonstrated that both boys and girls were using the centres and that the numbers of youth gradually increased over time.

Below are a couple of examples of how the needs of local young people were identified in Bangladesh:

- Working closely with young people in one geographical area helped to identify other, less 'visible' groups of young people who needed support – such as youth in prisons and refugees in need of specific support in Cox's Bazaar.
- The youth attending the FPAB youth centre would help other youth to advocate with their parents. In one case (described in Peer Education – A Review of Stakeholder Experiences) peer educators and youth attending a centre, with the support of project staff, helped a girl of 15 to avoid a marriage to a man from overseas, when she wanted to continue her studies.

BUILDING SKILLS AND JOB PROSPECTS

The vocational activities provided at the youth centres were also an interesting and successful approach. In Lao PDR, a survey conducted by the implementing partners found that 70% of CSWs wanted to leave their work. The projects provided vocational training opportunities for the CSWs in an effort to help them to leave sex work. While the success of this strategy had not been formally monitored, anecdotal evidence suggested that girls did make use of these opportunities and that a number of girls had set up small businesses utilizing their new skills, such as tailoring.

While the opportunity to learn vocational skills was popular with young people, and appreciated by the youth and community members alike, attempts to formalize these learning opportunities were limited. Few of the courses appeared to be certified, which meant that although youth were gaining skills, these were not validated for employment purposes. It would appear that there needs to be a greater focus on linking with ministries responsible for vocational training; that would be able to support and validate such courses. In addition, this may lead to improved sustainability as funders may be more willing to support validated courses.

Often the skills classes tended to reinforce gender stereotypical roles. For instance crafts, cooking, beautician courses and tailoring were provided for girls, while boys were encouraged to learn a technical skill such as carpentry or electrics (Pakistan). However, the introduction of computer courses did depart from this trend with both girls and boys having access to training. In future, care should be taken to avoid having projects reinforce gender roles. Furthermore, where the aim is to encourage young people to set up businesses, more importance should be placed on teaching practical skills, such as business, accounting and marketing.

YOUNG PEOPLE'S OPINIONS

From the interviews with young people, it became clear that the youth centres had achieved their objective of being seen as a safe space, a good information source and a way of meeting with friends; as well as offering an opportunity to build skills. The centres also provided an excellent focal point for the peer educators. Social activities were used to relay SRH messages and as an opportunity for youth (especially girls) to practice their new life skills, such as negotiation. Many of the girls mentioned how empowered they felt having had the opportunity to participate in dramas and debates related to SRH issues.

In the conveniently located centres and those that were seen as 'drop-in' centres, there appeared to be a growing number of young people using the facilities, for example in Nepal. However, where the centres were housed within SRH clinic settings, there appeared to be a fairly small group of 'regulars' using the centres with fewer young people just 'dropping by'. The young people who visited the youth resource centres in the RHAC SRH clinic in Cambodia did say that friends needed convincing to come to an SRH clinic, as they feared people would see them and think they were going for services. A study from Kenya had a similar finding that youth felt uncomfortable going to centres run by family planning associations³⁵.

³⁵ Erulkar, A. A. Mensch, B. S. Youth Centres in Kenya: Review of the Family Planning Association of Kenya Programmes Population Council, Nairobi October 1997.



CREATING OPPORTUNITIES THROUGH YOUTH FRIENDLY CENTRES

“I was a shy girl; I never participated in any event related to youth. To be honest, I was not sure of my own capabilities and strengths. I visited this youth friendly centre in my village one year ago. Impressed by the services and youth friendly environment, I became a regular visitor and gained confidence. Now I work with SACHET as a volunteer and young girls look up to me for their personal issues including sexual and reproductive health. I feel proud to be a leader for my peers.”

(SACHET, Pakistan)





Sustainability

Establishing youth centres as an approach is not new; Senderowitz (2000) conducted a review which included youth centres. The review found that several family planning associations in Africa had developed projects in which youth centres provided education, vocational and recreational activities in a youth friendly setting. Review of the youth centres in three African counties (Kenya, Ghana and Zimbabwe) found that, compared to the cost of supporting outreach/peer promoters components, the high cost of maintaining the centres in relation to providing services to clients was not justified given the results. However, WHO's systematic review of the evidence from HIV/AIDS prevention in developing countries recommended that there is a sufficiently strong evidence base to support widespread implementation of interventions to prevent HIV that are delivered within the framework of existing youth services organizations or youth centres³⁶; as was the approach in several of the RHIYA projects. RHIYA youth centres were more cost-effective when established within an existing building, thereby leveraging potential synergies of shared staff and resources.

In the RHIYA programme, independent, stand alone youth centres were resource intensive, requiring infrastructure, equipment and ongoing running costs, including staff training and salaries. Many of the projects across the RHIYA countries identified sustainability as a key issue. In Viet Nam, both the UPSU Final Report and VINAFFPA's Final Project Report asserted that the key to ensuring sustainability is to establish YFCs within existing community health centres, drawing on national buildings, staff and systems. Counselling and the provision of SRH services for youth and adolescents have become an integral part of the work of community health centre staff members.

In some circumstances, the community was attempting to keep the centres open, for example in Pakistan where implementing agencies were trying to use newly acquired local government funds, as well as working with local CBOs. In Lao PDR, the Women's Union said they had great difficulty in ensuring the sustainability of the youth centre and continued to rely on development partner contributions. In other countries, the centres were incorporated into existing buildings, which often contained NGO or public clinical services.

In Sri Lanka, service delivery points (SDPs) were often situated in government clinics or dispensaries – even under the project they had difficulty in developing and maintaining the infrastructure due to budget limitations. In Cambodia and Bangladesh, the youth resource centres were established in the RHAC SRH clinics (Cambodia) and in the different NGO SRH clinics (Bangladesh). These centres were still active at the time of the stakeholder review, as they were set up in established clinic environments.

In Nepal, EHDAG activities are planned, implemented, monitored and adjusted with the participation of the communities and youth leaders who have worked as peer educators – 528 youth both in and out of school. Through this involvement, the youth leaders have become owners of the initiative and the CBO 'Sahayatri Group' has been established. The EHDAG initiative will now continue beyond the project's close. Group members have been contributing 10 NRP a month as a fundraising initiative, while the young people have also initiated their own fundraising activities.

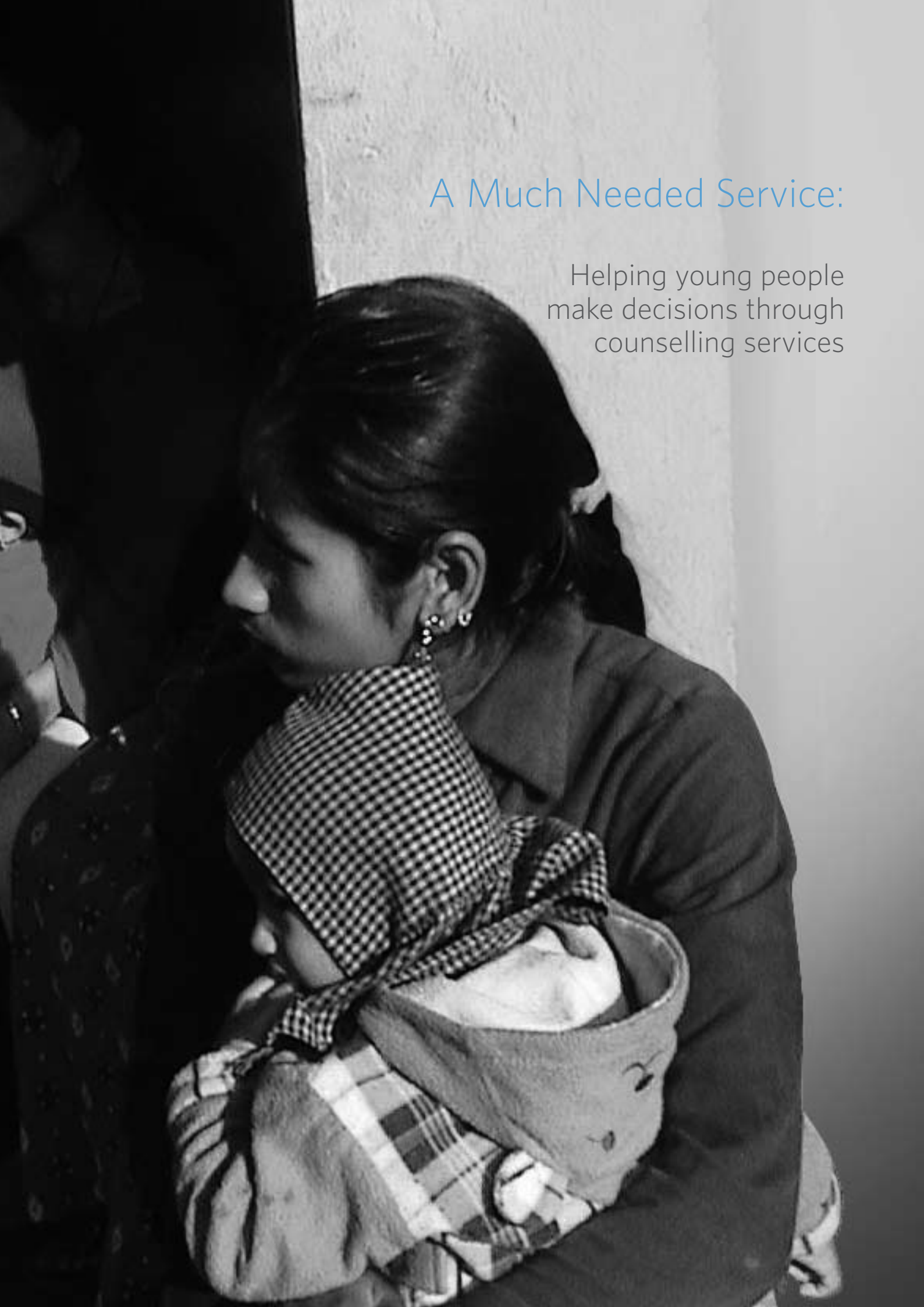
The most financially viable approach may be to directly fund governments to provide youth services for the majority of the population. The challenge is to sustain programmes aimed at the most vulnerable groups. These groups will continue to need targeted funding and intervention; as they have limited ability to contribute to their health care provision, but are likely to have significant unmet SRH needs. NGOs may be the most appropriate vehicle to meet the needs of this group.

³⁶ Youth organizations or centres already accepted by community; interventions that are sustainable and have capacity to move into HIV/AIDS programming. For a successful negotiation of entrance into organizations, HIV/AIDS education must have a logical fit with the organization. Peer educators should be chosen using specific relevant selection criteria, mentoring and support should be provided.



A Much Needed Service:

Helping young people
make decisions through
counselling services







KEY POINTS COVERED IN THIS SECTION:

- Counselling is often the most utilized service among young people.
- Young people and adults may view the characteristics of a good counsellor differently; the needs of young people must be considered when selecting counsellors.
- Maintaining confidentiality is an important aspect of quality counselling services.
- Recruiting and retaining counsellors may be difficult and costly in terms of staff turnover, training and supervision.
- Establishing and maintaining good referral networks between services is essential – referral networks need constant maintenance.
- Counselling services will differ depending on the needs of the target group – projects need to ensure they are not excluding groups that have a need, but who do not recognize the services are there for them.

Helping young people make decisions – counselling services

“My role is to help the young person feel that he or she has the information they need to take control of the events”
(Counsellor, Pakistan)

Counselling for adolescents and youth became one of the more popular services within the RHIYA programme. Stakeholders often stated that young people were actually in greater need of information, education and counselling than clinical SRH services. In YFCs in Viet Nam, clinical services were rarely provided; as the majority of adolescent and youth clients demanded counselling and information. However, it is not clear if this was because young people genuinely didn't need clinical services, or due to their embarrassment and fear of what clinical procedures might entail. A high percentage (40% - 60%) of the YFCs' counselling clients was hotline callers³⁷; this is discussed later in this section.

COUNSELLING – AN INTEGRATED APPROACH

All the RHIYA programmes promoted integrated SRH counselling³⁸, which looked at personal, social and SRH issues. Counsellors attempted to identify issues by undertaking a comprehensive assessment of the individual's SRH status and concerns. The counsellors interviewed emphasized that young people should be assisted to make decisions for themselves, based on the information and options provided by the counsellor. In addition, counsellors set up and maintained referral mechanisms and often accompanied youth to other services.

27 UPSU Coordinator speaks to a group of young people, RHIYA, Pakistan



Different services in different countries

Counselling services developed in different ways in different countries, depending on the needs of young people. The characteristics of the youth differed considerably depending on their age and social status; whether they were in school or out of school, working, married etc. In addition, the topics counsellors were required to deal with varied across the different settings and different cultural contexts. The table opposite gives a number of examples of how the services developed in the different settings and the kinds of issues discussed.

³⁷ Some staff reported that the hotline could generate an income so that other youth friendly services could continue to be “for free” and hence be sustainable.

³⁸ Adapted from ‘Comprehensive Counselling for Reproductive Health’, training manual produced by Engender Health (New York 2002)

COUNTRY	COUNSELLING SERVICES	TOPICS
Bangladesh	<p>Counselling was provided by female or male counsellors attached to the youth resource centres.</p> <p>Most commonly used youth friendly services were information giving and counselling with fewer young people requiring clinical services.</p> <p>Most young people seeking counselling were 14 years old and above</p>	<p>Forced Early Marriage – this was the concern most often raised during the interviews. The health and social effects on girls are considerable – having to drop out of education, being involved in dowry disputes leading to abuse and gender-based violence and the increased risk of maternal morbidity and mortality as a result of early childbearing, and HIV/AIDS (as a result of marrying an older more sexually experienced man).</p> <p>Lack of awareness of normal changes during puberty – in particular wet dreams; youth mentioned they were told by adults that wet dreams would make them weak ‘for every drop of semen, you lose 40 drops of blood’. Girls were particularly concerned about the personal hygiene aspects of their menstrual periods.</p> <p>Young men using the services of CSWs; and the risk of contracting STIs and possibly HIV/AIDS – Counsellors focused on discouraging young men from using CSWs as an initial approach, but also provided safe sex messages and condoms.</p>
Viet Nam	<p>All centres had a separate counselling area to maintain privacy.</p> <p>A high percentage of clients were unmarried (89.1% versus 10.9% married)</p> <p>More females than males were among their clients for counselling</p> <p>The majority of the clients were 15 years or over.</p> <p>According to some logbooks reviewed by the consultant, counselling for adolescents and youth continued into January 2007 – after the project had ended – but the room (in a semi-urban setting) is now also used for adults.</p> <p>Effective monitoring remained a key challenge in Viet Nam, however, due to the structure of the RHIYA programme and the large number of partners operating at different levels – including NGOs, the Youth Union, technical agencies, subcontracted agencies; central, provincial, district and community level partners .</p>	<p>In Viet Nam ‘face to face’ counselling was the most popular service, followed by hotline counselling.</p> <p>The popularity of hotline counselling may be due to the fact that sexuality, love and relationships are issues among young people and they feel safer discussing these sensitive issues with the anonymity the hotline provides them.</p>
Nepal	<p>The Improvement of SRH & Prevention of HIV/AIDS & Drug Abuse among Adolescents and Youth in Urban Poor Communities project emphasized the ‘drop-in’ nature of the four YICs (two in Dharan and two in Pokhara).</p> <p>In an average quarter around 750 youth dropped in to the four centres.</p> <p>Similar number of boys and girls using the facilities.</p> <p>Youth tended to develop the habit of ‘dropping-in’ to the YICs whenever they had free time.</p> <p>Counsellors were available and youth were able to access counselling when required.</p>	<p>Nepal pioneered work with gender-based violence: The Public Health Concern Trust (PHECT) integrated gender-based violence into SRH services in the rural district of Dolakha.</p> <p>Girls and women (married and unmarried) who had experienced gender-based violence were identified through a screening process.</p> <p>Individuals and communities were assisted to understand that the nature of the problem is sociocultural, not personal. This approach is reviewed in-depth in the RHIYA case studies³⁹.</p>
Pakistan	<p>Trained counsellors were situated in every YFC.</p> <p>All the counsellors were trained using a manual and training materials developed by PAVHNA, one of the implementing NGOs.</p> <p>Female and male counsellors were employed to address the separate needs of girls and boys.</p> <p>The counsellors were very motivated to serve young people. In a society where speaking about SRH issues is such a taboo, having confidential counselling services provided in a non-judgemental way proved to be very successful, and was used by both youth and parents.</p>	<p>Counselling was seen as an important element in reducing high maternal mortality rates in Qila Saifullah.</p> <p>Premarital counselling for couples was introduced to combat the severe maternal mortality problem.</p> <p>Discussions about family planning and also maternal health were included in the counselling.</p>

³⁹ Case Studies from RHIYA: Good Practices in Clinical Services & Comprehensive Programmes EU/UNFPA Reproductive Health Initiative for Youth in Asia (RHIYA) 2006

COUNSELLING – NOT JUST FOR YOUNG PEOPLE

In Pakistan, counselling was also provided to parents. This occurred as parents became more involved in the youth centre activities; it was an important factor in the youth centres gaining community approval and also helped facilitate relationships between parents and their adolescent sons and daughters.

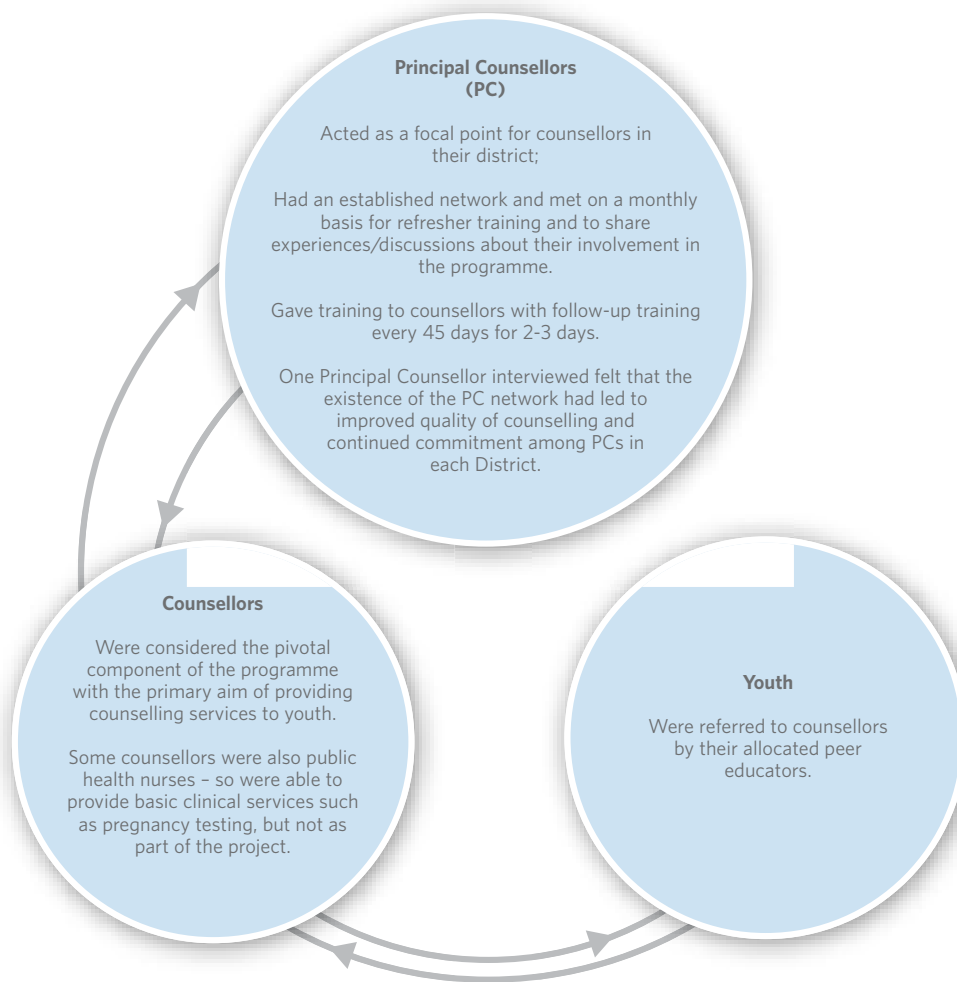
“I was having problems dealing with my 17 year old son. I thought he was not respecting me because he was influenced by the bad company of his peers. I was approached by the RHIYA counsellor to discuss the psychological issues of my son. After listening to the counsellor, I tried to be very friendly and helpful towards my son to help him overcome his fears. He has now started sharing his issues and problems with me. I am thankful to RHIYA for opening my eyes and helping lessen the communication gap between me and my child”
(Mother, Pakistan)





A UNIQUE STRUCTURE IN SRI LANKA

In Sri Lanka, counselling was a major component of the RHIYA programme and the organizational structure was quite unique among the RHIYA countries, as illustrated below:



The role of counsellors within the Sri Lankan approach has been an important entry point for the creation of an SRH referral system; as well as being important in the creation of an enabling environment supportive of the RHIYA projects' objectives and activities. Counsellors, for example, were responsible for organizing and attending awareness raising programmes together with the peer educators. Although counsellors were employed for a set number of hours a week, they were flexible as to when they worked and those interviewed said they were more than happy to be contacted by peer educators/peers at any time of the day if needed.

Selecting and training counsellors

The table below summarizes how the counselling services were established and managed; many of the features were similar across the 7 RHIYA countries.

SELECTING AND TRAINING COUNSELLORS	
People employed as counsellors	<ul style="list-style-type: none"> • Part time counsellors – teachers, public health inspectors, estate medical assistants, public health nurses, social welfare officers, local administrative officers, youth officers, community health promoters, family health assistants and NGO personnel. • Full time (project staff) counsellors – specifically trained counsellors who then became project staff attached to a youth centre. • Young people – peer educators trained to provide counselling services as often young people prefer to talk to their peers (Viet Nam).
Selection process	<ul style="list-style-type: none"> • Often people were approached by the project staff, especially existing health workers and respected community members. • Project staff felt this was an appropriate selection process, as ‘counselling’ is a relatively new concept in countries such as Sri Lanka and so respected members of the community would be better accepted by parents and community leaders – especially important in areas where there was community opposition to SRH services.
Training counsellors	<ul style="list-style-type: none"> • Usually the responsibility of a project implementing partner with experience in training counsellors. • Uniform trainee and trainer manuals developed – allowing for joint supervision etc. • Follow-up supervision, especially for new counsellors.
Quality Assurance	<p>Various approaches to monitoring quality were adopted across the RHIYA countries:</p> <ul style="list-style-type: none"> • Site visits – in all 7 countries, project partners conducted numerous visits to project sites with the aim of monitoring the quality of project interventions. Checklists were used by supervisors to ensure uniform supervision. • Counsellors meetings – regular meetings were held between counsellors and supervisors, to discuss cases and any problems and issues the counsellors felt would help them improve their services. • Refresher training and study tours – counsellors received refresher training and had the opportunity to visit other project sites to learn about how project interventions were managed.

While counselling is a highly recommended programming approach, its effective implementation depends greatly on the quality of training and the preparation of counsellors to ensure a specific focus on the needs of young people⁴⁰. This is particularly important in countries where a ‘counselling culture’ was a relatively new approach.

⁴⁰ Senderowitz, J. (1997) Health Facility Program on RH for Young Adults FOCUS on Young Adults Research Series

COUNSELLOR CHARACTERISTICS

As the table below demonstrates, there was a divergence between what adults and youth viewed as a ‘good counsellor’. This has implications in terms of recruitment and how counsellors are prepared for their role.

WHAT MAKES A GOOD COUNSELLOR?	
Project Staff	Young people
<ul style="list-style-type: none"> • Good interpersonal skills (listening). • Believe that young people should have access to SRH services. • Be respected members of the community. • Close physical proximity to the community. 	<ul style="list-style-type: none"> • Being a good listener. • Knowledgeable about the topic and the options available. • Empathetic – know how young people feel about things. • Trustworthy – able to keep a confidence. • Non-judgemental – accepting that sometimes young people make mistakes. • Be part of a good referral network – know where and how to refer.

MAINTAINING CONFIDENTIALITY

Confidentiality was seen as an essential principle for youth workers, in particular the youth counsellors. Youth responded well to this approach and a number stated that their confidence in services had increased due to the fact that counsellors had kept confidences. An additional room for counselling further emphasised the confidential and separate nature of the services. In Cambodia, the RHAC SRH clinic and youth centre provided a separate waiting area for young people in the youth clinic to maintain privacy and confidentiality. Counselling was conducted in a separate room.

However, maintaining confidentiality when delivering counselling services remains an issue in some facilities. For example in one instance there was no door between the clinic and the waiting room to ensure privacy. A lack of funds, however, meant that not all facilities could be upgraded (Sri Lanka).

RANGE OF COUNSELLING ISSUES	
General issues	Alcohol related violence, alcoholism, rape, attempted suicide, mental health problems, unplanned pregnancies, sexual harassment and family planning.
Topics most requested by girls	Body changes during adolescence, the reproductive system, love & relationships and ways to deal with sexual harassment.
Topics most requested by boys	Incest, drug/alcohol use, questions about girls/sexual activity, and the risks of going to a commercial sex worker.

Many of the issues identified were very sensitive and required the counsellor to provide information, options and referral routes, but ultimately required the young person to make personal choices. A number of young people said they felt more confident in their own ability to problem solve as a result of the counsellors’ youth friendly approach and ability to present options rather than just providing solutions.

Issues and constraints

HIGH STAFF TURNOVER

In both Bangladesh and Pakistan, the recruitment and retention of counsellors was often cited as an issue; in particular the difficulties recruiting female counsellors. At the time of the stakeholder review, neither male nor female counsellors were in post in one particular centre in Bangladesh. In Pakistan, the projects tried to recruit counsellors from the locality to avoid a high turnover of staff. A high counsellor turnover is inefficient in terms of both time and costs involved in recruitment, training, and supervision of new counsellors.

TRAINING YOUTH AS COUNSELLORS

Previous work suggests that the effectiveness of youth counsellors depends on the client's circumstances, the topics discussed, whether the counsellor is known to the peer and whether the peer believes the counsellor is competent enough to handle his/her concerns⁴¹. Youth counsellors in the RHIYA programme were carefully selected and the range of topics they counselled on were relevant to the young people in their area.

CHARACTERISTICS OF A COUNSELLOR

While the counsellor characteristics identified by project staff and youth are not mutually exclusive, young people focused more on the type of services they were looking for: empathetic, non-judgemental etc. whereas the project staff focused more on practical issues, such as being a well respected member of the community or being at close proximity to the community. This may be why young people are seen to make good counsellors, as they were aware of what young people want from a counsellor. Furthermore, this emphasizes the need to screen and select counsellors in accordance with criteria established in consultation with young people.

MONITORING QUALITY

Maintaining the quality of counselling and monitoring utilization was an issue in a number of settings. In Sri Lanka, interviews with Project and District Coordinators highlighted the fact that the quality of counselling and the motivation of counsellors was sometimes a concern and not all provided a similar level of support and service. All NGOs used the same workbooks and sheets to capture monthly information on the number and type of contacts/counselling made. In addition, counsellors used referral sheets to record information on the individuals seeking advice and details of referral. However, the accuracy and legitimacy of the counsellors' records was difficult to verify and relied on their ability to maintain accurate records. In many cases counsellors worked quite independently and it was unclear how their counselling standards were maintained. A mystery client approach may provide a better analysis of quality, rather than client exit interviews which were universally very positive about all the services (as discussed in the section We Need to Know).

TARGET GROUPS

Often more unmarried young people used the services than married youth. Both boys and girls used the services and, in some cases, more girls than boys. For the most part, youth aged 14 years or over used the counselling services. In Pakistan, the services were also seen as appropriate for use by adults and dealt with specific issues as dictated by the location – such as maternal mortality in Qila Saifullah, as mentioned above. Care should be taken by project staff to avoid inadvertently excluding some young people; the services need to be marketed within the more general health services, such as in antenatal clinics to alert young married women that these services exist and are available to them.



| 29 MSCS: Counsellor and client, Mymensingh, Bangladesh



REFERRAL

An important aspect of youth services was referral to other services such as health services. Notable in all the RHIYA countries was the degree to which projects had developed referral networks between different agencies.

TYPES OF REFERRAL	COUNTRY SITUATION
<p>Referral to other NGO/ public service providers within the project – this is the easiest and most acceptable to young people. In some instances, the implementing partners were able to refer to their partner organizations which created good links between the partners and added value to the RHIYA programme in general</p>	<ul style="list-style-type: none"> • Cambodia – RHAC resource centres and FRIENDS services for street children were able to refer within their own system. In addition, when needed project staff accompanied street children to clinical facilities outside the project; staff could then act as advocates for the street children and cover costs incurred. • Bangladesh – in the MSI and FPAB clinics, youth were referred within the services. • Nepal – YICs would most often refer to the RHIYA projects youth friendly service delivery points or youth friendly service centres⁴². Many of these were MOH facilities whose staff had been oriented and trained in providing youth friendly health services. • Pakistan – the NGOs would often refer clients to private practitioners who had been oriented towards the programme, or to the other implementing NGO clinical services – see box ‘Knowing where to turn’ below.
<p>Where services were not provided by the NGO/ public provider within the project, referral was made to other providers – this required strong referral networks to be established.</p>	<ul style="list-style-type: none"> • Lao PDR – The Vientiane Youth Centre developed strong networks with various institutions providing clinical services such as VCT and treatment for STIs, and provided peer educators with lists of referral sites. • Sri Lanka – the counsellors reported good links with Medical Officers of Health, District Medical Officers, government clinics and hospitals. PCs would call the Medical Officers, fill in the referral sheet (standardized across the programme) and accompany the young person to the clinic/ hospital as needed.

In most cases, referral was needed to other clinical services and was requested by the service provider. The referral network observed an agreed referral protocol, whereby the peer educators had a list of sites for referral and the referral agencies met regularly to discuss issues and ways in which to strengthen the network. However, this mechanism required maintenance and regular retraining and reorientation activities to ensure that any new staff in the referral agencies were brought up to speed on protocols and how to adopt a youth friendly approach.

131 CDA: An Estate Social Worker expresses her views on a street theatre production, Sri Lanka



⁴² A total of 55 YFSDPs have been located in existing MOH facilities (30), 20 in NGOs and 5 in Private sector. In some locations the YICs and YFSDPs were established in the same building



KNOWING WHERE TO TURN –
educating people on service availability

One counsellor had been approached by a woman within the community who asked if she could listen to the RH sessions. After checking with the youth to see if they objected to the woman sitting and listening to the sessions, the woman was able to join in. Following the session on family planning, the woman approached the counsellor and said her unmarried daughter was pregnant and she did not know which services she should take her to. The counsellor gave the woman information on the availability of RH clinic services.

(PAVHNA, Pakistan)





IMPORTANT FACTORS IN DEVELOPING GOOD REFERRAL NETWORKS:

- Referral can be to both private and public facilities, depending on their availability, however, the facility staff should be trained in providing youth friendly services.
- Where possible a full range of SRH services should be available at the referral site to avoid young people having to move between service sites – as they are often anxious about how service providers that they do not know will react to them.
- Referral networks need to be set up at the beginning of the project, mapping local facilities that are willing to link with the project and adapt their services to meet the needs of young people.
- Orientating the referral staff to the project's objectives and training in youth friendliness is essential – this may need to be repeated several times during the project lifetime.
- Cost is a consideration – the cost associated with treatment at the referral institution can be prohibitive and therefore arrangements need to be made to either cover the costs of the referral or to negotiate discount rates for young people.
- Establishing a referral protocol is important – so that staff know when to expect youth, what format the referral will adopt in order to ensure that youth are welcomed and made to feel comfortable.
- Having two to three 'point people' within the referral facility ensures that youth are directed to the 'right' people who are aware of their needs and are willing to provide services and someone would always be around to help.
- Regular meetings between the institutions within the referral network help to ensure the referral network is maintained and improved.
- A feedback mechanism to the referring institution is important, especially if youth need follow-up care, treatment and support.



Our Health Matters:

Meeting reproductive health
needs through clinical services
for young people







KEY POINTS COVERED IN THIS SECTION:

- Young people of different age groups need services that aim to meet their specific needs at each stage of adolescence.
- Service sites should aim to provide as extensive a range of services as possible to avoid unnecessary referral; bearing in mind the types of services in most demand and allocating resources accordingly.
- Careful consideration of the cadre, roles and responsibilities of staff should avoid duplication and waste of skills, and may increase retention of health workers.
- Whenever possible NGO and government services should work together to scale up youth services.
- Utilization of clinical services is an issue – this may not necessarily be due to a failure to provide appropriate services, but may simply be that young people require clinical services less often than counselling, information etc.

Meeting SRH needs – clinical services for young people

“Condoms and pills are now easily available at the youth information centre. Before the programme they were available only at the hospital”
(24 year old male teacher, urban Syangja, Nepal)

Over recent years, attention to providing adolescent and youth friendly health services has increased for a number of reasons. Worldwide, 50% of HIV transmission takes place among those aged 15–24 and 5,000–6,000 young people become infected every day⁴³. The second decade of life is a period of experimentation and risk, and many factors increase young people’s vulnerability to HIV during these years of rapid physical and psychosocial development. In addition, there is an acknowledged link between early and frequent childbearing and high maternal mortality rates.

The aforementioned WHO⁴⁴ review (2006) explored data from research studies into interventions to increase young people’s use of health services in developing countries. The review concluded that despite constraints related to the quality of data from studies in the review, there is sufficient evidence to support widespread implementation of interventions that include elements of training for clinical service providers and other clinic staff. Making improvements to facilities, and informing and mobilizing communities to generate demand and community support were also considered appropriate interventions.

While there is a growing need for youth friendly services, availability remains limited, especially in government facilities. At the RHIYA baseline, pharmacies were the main source of services, but as a result of the programme the endline indicators show that increasingly NGO clinics are providing services. For example, the 2006 endline survey in Nepal found that the most mentioned location to obtain or buy contraceptives was, in order of preference, health stations, hospital/clinics, pharmacies and FP centres.

⁴³ UNICEF, UNAIDS, WHO. Young People and HIV/AIDS – Opportunity in Crisis. New York, UNICEF, 2002. & 13. UNAIDS, WHO. AIDS epidemic update: December 2005, (http://data.unaids.org/Publications/IRC-pub06/epi_update2005_en.pdf).

⁴⁴ Ross, D. A. Dick, B. & Ferguson, J (2006) Preventing HIV/AIDS in Young People a Systematic Review of the Evidence from Developing Countries UNAIDS Inter-agency Task Team on Young People. WHO



“Family planning methods are easily available for young people in this area. Previously they were distributed at the health post to married people only, but these days they’re available to everyone. One can easily get condoms from the condom box kept in the youth information centre”

(Male local leader, rural Dang, Nepal)

“Contraceptives are easily available from general shops and Female Community Health Volunteers. They’re also available from the youth information centre operated by RHIYA free of charge. Not only contraceptives, but also appropriate advice and suggestions can be obtained from the youth information centre”

(28 year old female teacher, rural Kanchanpur, Nepal)

A study in Nepal suggested that irrespective of the type and nature of the SRH problems, adolescent girls generally did not seek medical attention. Certain SRH problems related to menstruation and vaginal discharge were considered normal or that they just ‘happen’ to girls. Only when problems got worse would they visit health posts or private clinics⁴⁵. The endline data provided in **Catalysts for Change – A Synthesis of RHIYA’s Achievements** demonstrates that in RHIYA countries girls still continue to seek services less often than boys. When designing youth friendly health services, addressing the needs of girls is an important consideration. To date, programmes have tended to address the expectations and needs of both sexes in similar ways, but there is a need for more disaggregated information, for example through focus group discussions with girls or through Participatory Learning in Action (PLA) methodologies.

| 36 German Goodwill Ambassador’s visit, RHIYA, Cambodia © Nhem Sothun



⁴⁵ Adolescent Health and Development in Nepal. Status, Issues, Programmes and Challenges. A country Profile 2005. Ministry of Health and Population, Dept of Health Services, Family Health Division.

Different Models for Providing Services

Different models for providing youth friendly health services (YFHS) have been developed worldwide, often depending on the resource envelope available. In low income countries, NGOs have usually lead the way in providing YFHS, with few governments providing designated services for adolescents and young people. In some countries, health centres for exclusive use by young people have been established, such as the Vientiane Youth Centre in Lao PDR. In most instances, however, YFHS have been implemented using existing SRH SDPs; both public and NGO. Details of the different models used in providing YFHS across the RHIYA countries are provided in Appendix 1.

COMPARATIVE ADVANTAGES OF DIFFERENT MODELS

The models used within the RHIYA projects were quite diverse, ranging from static NGO and public health clinics to mobile services and distribution of condoms and pills through peer educators. NGOs have worked with public health facilities to improve the youth friendliness of existing public health clinics.

MODEL	COUNTRY	DESCRIPTION
Use of existing public commune-level health centres	Viet Nam	After training in providing YFHS, public commune-level health centres have been successful in attracting a greater number of young people for SRH information and services. The endline survey shows that 'ever used' modern contraceptives increased from 62.1% at baseline to 82.3% at endline. In addition, those using modern contraceptives at last intercourse increased from a baseline of 47.4% to 66% at endline.
	Nepal	Some SDPs targeting more marginalized groups have been situated in public health facilities and can function as drop-in centres.
Alternative approaches to static clinics	Lao PDR	Mobile clinics were used in rural Lao PDR to reach youth in hard to reach areas; these were successful in that, among rural youth, the knowledge of two methods of contraception went from 19.2% at baseline to 58.8% at endline. In addition, the numbers of sexually active youth who stated they have 'ever used' a form of modern contraception rose from 24.1% at baseline to 52.3% at endline. These demonstrate significant changes in the ability of young people in rural areas to access modern contraception. Community Based Distributors.
	Sri Lanka	Community Based Distributors.
	Viet Nam	Pharmacies, private clinics and social marketing of pills and condoms. The percentage of sexually active respondents having used a modern method of contraception at last intercourse increased from 33.7% at baseline to 48.2% at endline (condom) and from 13.7% to 20.6% (use of the Pill).

In Cambodia, there was an increase in utilization of general public health services under the RHAC assistance to public services, but little evidence has been found that SRH related services had increased⁴⁶. Working closely with existing government systems appears to be a sustainable model; however, governments face many problems in relation to public health staff availability and their interest in providing youth friendly services. In addition to poor infrastructure within public facilities, which does not allow for separate entrances or areas for young people.

The public/NGO partnerships established to scale up services are promising and need to be further explored. Another aspect that also needs consideration is whether or not government services would be able to adequately meet the needs of marginalized groups, and whether or not there will always be a need for NGOs to focus on these groups while public services focus on more mainstream groups. Notable was the fact that, while young people said their peers used pharmacies, pharmacies were often not included in the RHIYA programme.

The **Country-based Monitoring and Evaluation Reports** and the end of project synthesis report – **Catalysts for Change** – provide data, which clearly demonstrates that the RHIYA programme was able to increase access to quality SRH services within a number of settings and among different target groups.

Target Groups

Across the 7 countries, target groups and the ways in which their needs were met varied widely. The most commonly cited target groups were urban or peri-urban youth; the age range was often specified as 10-24, but discussions with stakeholders revealed that, in reality, the services were most often used by youth aged 15 years and over. However, in projects specifically targeting vulnerable groups, such as street children, the age range was wider and younger adolescents used the services, including general medical services for young people.

URBAN AND RURAL YOUTH

In Lao PDR, rural youth were served by a mobile clinic, but beyond this staff said that services for youth outside Vientiane were limited. A similar situation was found in all of the RHIYA countries. The data for urban and rural youth was disaggregated and demonstrated that the focus on rural youth was especially successful, with perceived ease of access to contraception increasing from 29.8% at baseline to 49.8% at endline. However, the difference between males and females was striking: 80% of males thought they could access contraception easily, compared to only 50% of women. This raises the question of whether boys and girls need to be considered as two distinct target groups; with different approaches to increasing their access to services. Again, in Viet Nam, rural youth benefited greatly from the provision of services as indicated in the endline reports.

GARMENT FACTORY WORKERS

In both Bangladesh and Cambodia, services aimed at meeting the needs of factory workers, in particular garment factory workers. Many of these workers are migrants from provinces, separated from their traditional social safety networks. In Cambodia, emergency health unit nursing staff were equipped with the knowledge and skills to meet the needs of young workers. These services were well utilized by the garment factory workers, both girls and women.

VULNERABLE AND MARGINALIZED YOUTH

In Cambodia, street children were able to use the FRIENDS static clinics, mobile services and drop-in centres. This flexible approach to providing services took into account the high mobility of street children. The survey results demonstrate that the proportion of young people who were sexually active and used modern contraception increased from 52.8% (baseline) to 72.3% (endline). For young males, the trend increased from 61.9% in the baseline to 79.1% at endline; while for young females, there was an increase from 39.8% (baseline) to 61.7% (endline).

In Nepal, SDPs aimed to target marginalized, vulnerable and underserved groups including: low casts (e.g. Dalit) slum dwellers, school dropouts, drug addicts, the unemployed, and illiterate girls. Over 60% of the endline survey respondents were from disadvantaged groups, showing how successful the projects were in reaching these youth. Youth were encouraged to utilize the services through outreach activities by project staff and word of mouth from other users of the services.

While the RHIYA programme catered for marginalized and more vulnerable youth, the needs of married youth were not so well catered for. While the focus of IEC activities in Bangladesh was to delay the age of marriage and first birth, if a married adolescent became pregnant, more often than not they would be cared for in the adult antenatal clinic (ANC). While married adolescents would be readily accepted in adult ANCs, they are often still between the age of 15-19 years and continue to have specific needs, which would not be addressed in these clinics. Bruce and Chong⁴⁷ highlighted the vulnerability of married adolescents, emphasizing the fact that young married girls are living apart from the presumptive protection of family or school. Girls living in societies where child marriage is common and/or the HIV epidemic is disproportionately affecting young females are also particularly vulnerable. In addition, married girls are placed under intense pressure to become pregnant, facing social rejection and even violence in some circumstances if they do not bear a child rapidly (usually within the first 20 months after marriage).

⁴⁶ Imani, N. Report on the Review of Adolescent/Youth Friendly Sexual and Reproductive Health Services in Cambodia, UNFPA 2006.

⁴⁷ Bruce J and Chong E (2005) The Diverse Universe of Adolescents, and the Girls and Boys Left Behind: A Note on Research, Program and Policy Priorities – Millennium Project



Range of services

The range of services varied considerably across the countries, with some clinics providing a full range of SRH services and others a more limited range with referral to other facilities. A number of examples from some of the RHIYA countries are provided in the table below in order to demonstrate the variety of services available.

COUNTRY	SERVICES
Bangladesh	<p>Through FPAB and MSI – a range of general and SRH services were available:</p> <ul style="list-style-type: none"> • General health and physical examinations, nutritional counselling. • STI screening, counselling and treatment. • HIV testing and counselling. • Contraceptive choice. • Post-abortion care services. • Pregnancy testing, antenatal/post-natal care, TT immunization. • Premarital counselling. • Assistance to victims of rape.
Cambodia	<p>Clinic setting:</p> <ul style="list-style-type: none"> • General health and physical examinations, nutritional counselling. • STI screening, counselling and treatment. • HIV testing and counselling. • Contraceptive choice. • Safe abortion services (where legal) or post-abortion care services. • Pregnancy testing, antenatal/post-natal care, TT immunisation. • Premarital counselling. • Rape assistance. <p>Outreach services:</p> <ul style="list-style-type: none"> • Street children in Cambodia, outreach services were provided actually on the street. • Staff wore specific t-shirts so that the children recognized them. • If required, young people were referred to the FRIENDS static clinic; utilization was good and follow-up provided. • If children did not return for follow up, the staff from the centre would go and search for them. • Services used the most by young people include general consultation, FP and STI treatment. • Condoms available from peer educators. • No appointments needed in the clinic: 'in our services they do not have to wait'. • There is a mobile youth centre in the squatter areas outside the city, where services are free and many of the street children return time and again for services.
Lao PDR (urban and rural services)	<p>The Vientiane Youth Clinic has witnessed a steady increase in utilization from 241 young people, at its opening in 2001, to a total of 1,504 users during 2005.</p> <ul style="list-style-type: none"> • 70% of consultations were for STI counselling and treatment. • Counselling and basic services only – syndromic management was provided but no laboratory facilities were available. • The Vientiane Youth Clinic is highlighted in the RHIYA best practices guides for its youth friendly approach⁴⁸. This clinic is part of a very well developed and monitored referral system between both public and private services within Vientiane. <p>Also available in Vientiane and through the mobile services:</p> <ul style="list-style-type: none"> • FP services including condoms and oral contraceptives. • Pregnancy testing, and HIV testing and counselling.
Viet Nam (urban and rural services)	<ul style="list-style-type: none"> • Collaboration between NGOs, the Youth Union and public services provided a range of youth friendly services, including clinical services. • Trained health workers provided services from 7am until 7pm, seven days a week, on a drop-in basis. • Youth drop in for reading materials. • For counselling and clinical care, the staff focus on ensuring a private and non-judgemental environment. • To help ensure confidentiality, clients are asked not to provide their names or any personal information. • Services include general medical care, counselling, contraception free of charge and safe abortion. • More details can be found in You Are Welcome Here: Good Practices in Counselling & Clinical Services (RHIYA 2006).

While there may not be a huge demand for services, in terms of the number of young people requiring clinical services, the range of services available for young people is important. Providing a full range of health and SRH services reduces the need for referral – youth are often nervous about being referred between facilities as they fear the reaction of the next service provider. The extent of services required will differ depending on the youth target group, and the availability and accessibility of other services.





Making it Work:

Facilitating and constraining factors in providing services to young people



Facilitating factors

“In the past [young people] hesitantly turned up at the door, not daring to enter the friendly corners for consultancy and service. And when inside the corner, they kept sitting still and wordless. But now, on arriving at the corner, they come in confidently and ask direct questions”
(Doctor of the Youth House, Hanoi, Viet Nam)

A number of factors facilitated the work of youth clinics, these included:

Improvements in government policies

Improvements in government policies in support of service provision for young people helped to create an enabling environment for the RHIYA programme. For example, in Cambodia, the Secretary of State of the MOH was very supportive of RHIYA, which had a significant influence on shaping government ASRH policy, including the RH Strategy and Strategic Plan, 2006-2010, and the National Guidelines for Adolescent Friendly SRH in Cambodia, both approved in March 2006.

Knowledge of the field and youth needs

Implementing partners were also able to influence changes in government policy and strategy due to their knowledge of both the field and the needs of young people. In Pakistan, ARH is a neglected area at national level, with no government policy for provision of IEC or services for young people. RHIYA NGOs together with UNFPA, however, have had important inputs into the draft Youth Policy, which now includes ARH.

Strong advocacy

Advocacy efforts at all levels by the implementing partners continued throughout the projects; informing and involving the community. The RHIYA programme in Viet Nam provides a very positive example of effective advocacy; the carefully designed, complex and highly participatory structure linking executing and implementing agencies, supporting organizations and institutions brought together partners and authorities, and will contribute to the projects' long-term impact.

Using/leveraging existing service providers

In areas where NGOs were already trusted SRH service providers, they were able to introduce youth services with the knowledge and consent of the communities in which they had facilities, and were also able to subsidize services for young people. In Bangladesh, Pakistan and Nepal, for example, Marie Stopes, a pioneer in developing youth friendly services, has been a key partner. Working with well established NGOs has also been an effective way to access particularly difficult areas or groups, such as serving internally displaced persons in Sri Lanka.

Adopting an integrated approach

The RHIYA NGOs adopted an integrated approach; providing information, counselling, social activities and clinical services. RHIYA supported the setting up and/or strengthening of youth centres (which were usually run by local NGOs) to provide a broad range of educational and recreational activities to young people, and in some cases, youth friendly counselling and clinical services. The Vientiane Youth Centre, for example, is the first clinic in Lao PDR to offer SRH services solely designed for young people, including treatment as well as prevention, counselling and information services.

Constraints

YOUTH MOBILITY

Marginalized adolescents and youth are usually a highly mobile population. Many young people from Lao PDR and Cambodia would migrate to Thailand; project staff said they would even begin taking illegal drugs and return home already addicted. Follow-up and support during clinical treatment was also a challenge and, in some cases, project staff had to seek out young people who did not return for follow-up visits. In addition, behaviour change is harder to achieve with street children as there is a need to first build and develop relationships.

ADULT ATTITUDES

The attitudes of adults within a community can challenge the very existence of services for young people, so they need to be involved throughout the planning and implementation processes. In Viet Nam, the Mother and Daughter, and the Father and Son clubs ensured that parents were kept involved and informed, details of these clubs are contained in the **RHIYA Good Practices Guides**. Key community stakeholders also need to be involved. In Cambodia, city police were trained to deal with street children without just moving them along; the police began to refer children to the FRIENDS services.

SUSTAINABILITY

Sustaining clinical services for young people is a challenge. All stakeholders agreed that, since the services had been heavily subsidized during the project implementation period, it was difficult to maintain the same level of services after the project was completed.

RESPONDING TO THE CHALLENGE OF SUSTAINABILITY:

- Several NGOs have attempted to continue subsidizing youth services through their adult services, but this was not very effective as so many of the young people are poor and cannot afford the services.
- Efforts to involve local government in sustaining projects have been very limited, consequently many activities were not sustainable.
- Attempts have been made to sustain activities by obtaining more donor funding – however the EC and other donors are changing to programmatic support through government systems. This poses a challenge for youth focused programming, as often governments have not specifically addressed youth services in their Poverty Reduction Strategy Papers (PRSP) process and don't have costed plans for providing youth services. Even if there are plans, governments often lack the capacity to provide clinical services specifically for youth and, in particular, more marginalized groups. Until youth programming is firmly established within respective government systems, discreet project based funding for youth services may need to be continued.

If future programmes are to achieve sustainability, the following is needed:

- More research into ways in which services can be made sustainable before implementation begins; together with the creation of a sustainability plan to be embedded within the individual project workplans.
- Specific efforts focusing on obtaining local government support and buy-in to ensuring sustainability of services.
- Advocacy efforts on the part of NGOs to try and influence government policies to ensure that youth services are included and costed in PRSPs.
- Promotion of partnerships between governments and NGOs (with expertise in clinical service provision) until youth programming becomes integral to government systems.



ESTABLISH LINKAGES OF
RHYA GOVT AND LOCAL

بانی کی خدمت میں
مقدمہ



MARIE STOPES
SOCIETY







How to be Friendly:

Lessons learned and
next steps





KEY POINTS COVERED IN THIS SECTION:

- Consultation with young people will help define their specific needs in making services youth friendly.
- Youth friendly health services (i.e. respectful, empathetic and confidential) can still be provided even if there are limited funds available for infrastructure development.
- Health workers, other than doctors, are qualified and competent to provide SRH services for young people.
- It is important to recognize and accept that not every health worker is suited to providing services for young people.

Lessons learned in services for young people

“A place where young people feel comfortable to come and get services and a place that is able to cope with their needs. Young people are difficult to deal with, they are slow to admit what is wrong and what they are worried about, they don’t want to wait, they don’t want to lie down on the examination bed etc. We need to use the language they understand”
(Service provider, Nepal)

CREATING AN ENABLING ENVIRONMENT

- Advocacy activities for all community groups are essential to the successful implementation of youth friendly services – especially at the beginning of the programme, before services are operational.
- Increased advocacy with religious leaders is needed – the acceptance and introduction of the **Reproductive Health in Islam** booklet⁴⁹ and learning pack in Pakistan was a positive example of successful advocacy. UPSU and project partners became aware of the booklet during a regional meeting and suggested it would also be of value in Bangladesh.

PROMOTING AN INTEGRATED/HOLISTIC APPROACH

- Youth programming requires an integrated approach in order to address the range of young people’s development needs – these include both clinical and non-clinical services as well as social, recreational and vocational initiatives.
- Stakeholders felt that providing social and vocational opportunities also increased young people’s confidence in clinical and counselling services.
- Whenever possible comprehensive health and SRH services should be available under the same roof, to ensure referral is kept to a minimum, but these should be developed based on potential demand and specific context. For instance, if the client group is likely to include a high proportion of CSWs then STI counselling and services should be able to provide laboratory facilities.

REACHING VULNERABLE/HARD TO REACH TARGET GROUPS

- Scaling up youth service programmes to cover rural areas is possible using mobile services and community based distribution networks.
- Working with young people in a geographical area helps to identify less ‘visible’ groups of young people who need support, such as the youth in prisons and refugees who were identified as requiring specific support in Cox’s Bazaar, Bangladesh.
- There is a need to focus free or subsidized services on poor youth – implementing some form of eligibility testing would enable projects to better channel subsidies to those most in need, while also increasing chances of sustainability.

ENSURING A GENDER FOCUS

- Gender is a key factor – focusing on issues specifically affecting girls such as early marriage is important, in addition to addressing the needs of married girls in order to reduce their vulnerability to HIV infection and pregnancy-related mortality and morbidity.
- Girls continue to use clinical SRH services less than boys – using qualitative techniques to further explore this phenomenon may help to reduce the discrepancy.
- Girls and boys have some similar and some quite different needs – they should be treated as separate target groups with different strategies developed to address access, range and the types of services required.

PROMOTING PARTNERSHIPS AND LEVERAGING NETWORKS

- Public/private partners in providing youth services work well – NGOs have a lot of expertise and lessons to share, but also are able to effectively support community advocacy and demand side issues. Public facilities provide the scope to scale up to reach more remote areas and could benefit from using NGO staff and infrastructure to actually provide the youth services.

ADOPTING A NEEDS-BASED APPROACH

- A countrywide needs assessment, which systematically maps vulnerable groups, could assist in focusing programme activities.
- A more needs based approach should be adopted – all projects should begin with a local needs assessment, on which to base a detailed project design.

REFERRAL NETWORKS

Referral networks need to be carefully designed and maintained in order to meet the needs of young people, for example:

- Ensuring vulnerable youth are accompanied/ supported to referral sites where links are not yet well established.
- Ensuring referral staff are appropriately trained and sensitive to youth issues. In order to encourage young people to carry through referrals.
- Wherever possible comprehensive services should be provided on one project site to reduce referral travel time and reluctance to visit additional facilities.

SUSTAINABILITY

- Sustainability of youth friendly services remains a major challenge – more work is needed to identify how best to maintain youth friendly services. Especially as these services clearly make an important contribution to the health of young people. The RHIYA endline results suggest that many specific information needs were effectively met across the programme. For example, in relation to knowledge of the fertile period among youth, positive increases were seen; particularly in Lao PDR with a rise from 48.3% at baseline to 73.5% at the endline. These results are sustainable in themselves as now that the young people have the knowledge they will be able to maintain their own health, and that of their partners and family, more effectively.
- Partnerships between public and private organizations appear promising. In addition, mainstreaming youth as a target group within other programmes may also have some value; for example: addressing the needs of young girls as part of gender programmes, addressing the needs of young married pregnant girls as part of a safe motherhood programme or addressing the needs of young people in income generation programmes.

VOCATIONAL TRAINING

- Attempts to formalize vocational learning opportunities and link with ministries responsible for vocational training could provide official recognition and validation of the courses. This may lead to improved sustainability as funders would be more likely to invest in validated and certified courses.

Important factors for consideration when implementing youth friendly health services

DEFINING YOUTH FRIENDLINESS

The table opposite compares the results of the RHIYA stakeholder interviews with the UNFPA's work on youth friendliness; the same issues appear to remain important to young people.

CLINIC FACILITIES

In general, the NGO clinics either made changes in facilities or opened purpose built premises. In Vientiane, the clinic consisted of three rooms including the reception, a waiting room and a counselling/examination room (Lao PDR). Smaller clinics tended to provide a friendly and welcoming space to talk through issues where both confidentiality and privacy is assured. Most of the youth facilities visited during the review were brightly painted and had posters on the walls. Young people were encouraged to make the waiting rooms and information areas their own spaces by adding posters, artwork etc.

During the stakeholder review, it was noted that across the RHIYA countries, public health centres were often unable to make the changes in infrastructure that young people desired. For example, in Nepal, the youth friendly service delivery point interiors varied tremendously; from very simply furnished rooms with only minor overall changes (in public health posts) and rural private practices with modest changes, to NGO facilities where they were able to develop 'fashionable' purpose built spaces. To illustrate this, staff at a (sub) health post mentioned that the only difference between youth friendly and adult services was a separate logbook and plastic gloves, compared to an NGO clinic where two counselling rooms were available for the male and female counsellor for counselling males and females respectively.

In Sri Lanka, some attempts had been made to make RHIYA SDPs 'youth friendly' – including posters on reproductive rights and the SRH rights of young people, and small signs hung outside dispensaries to indicate a RHIYA project site, but there were few materials available.

Features of the RHAC clinics in Cambodia included a separate waiting area in the youth centre and even separate prescription handling from the general clinic. This provided a quality service with respect for the individual's wishes, their privacy and confidentiality. While youth do pay a fee for services if they are able to, those who are unable to pay are provided services free of charge.

YOUTH HEALTH CENTRE STAFFING

Throughout the RHIYA countries, different staff cadres provided services within different settings. In some countries, nurses were the main clinical health-care providers, while in other countries doctors were hired to provide clinical SRH services. In Bangladesh, FPAB tried to maintain a complement of one female and one male doctor trained in youth friendly health service approaches and a counsellor at each service delivery site. However, the turnover of doctors was very high, particularly outside urban areas. The high staff turnover meant continuous training for clinic staff throughout the project life and services lacked continuity. One member of the project staff said that perhaps doctors were not the best cadre to use as they sometimes had difficulty in adapting to the different set of young client needs.

In Lao PDR, although nurses were employed in the clinic, they were used to register staff, provide counselling and support, rather than to provide clinical SRH services. In Nepal, trained nurses or Auxiliary Nurse Midwives provided a range of general and clinical SRH services. Therefore, staffing patterns were not consistent across the RHIYA countries and further thought needs to be given to the optimal staffing mix. In many contexts, it may not be necessary to always have medical doctors to provide clinical services; and in many situations trained nursing staff can provide a full range of quality SRH services.

All RHIYA projects were cognizant of the gender balance among service providers; in some instances female clients were seen by only female health workers and male clients by male health workers. While this is ideal in terms of providing appropriate gender balanced services, it is costly in terms of having to employ both male and female doctors. In the Vientiane Youth Centre, however, where all the staff were female; they said that after overcoming their initial shyness, male clients were usually happy to discuss issues with them.

Using mid-level paramedic staff cadres may be more cost effective and efficient. In addition, attention needs to be focused on analyzing workload and service demands. The gender mix would need to be determined depending on the cultural context.

WHAT MAKES HEALTH SERVICES YOUTH FRIENDLY?	
UNFPA 2003 defines ⁵⁰	Stakeholder Review (2007)
<p>Service providers</p> <ul style="list-style-type: none"> • Service providers specially trained • Respect for young people • Privacy and confidentiality • Adequate time for client/provider interaction 	<p>Specific characteristics of staff</p> <ul style="list-style-type: none"> • Peer counsellors available. • Ability to listen. • Ability to understand the SRH concerns of the target group. • Professionally skilled and able to provide quality services. • Able to provide guidance on issues which may not be related to SRH patient. • Be “Young and free minded”. • Able to explain SRH issues in a simple manner. <p>Attitude of staff</p> <ul style="list-style-type: none"> • Respectful, non-judgemental approach. • Expression of real interest in adolescent and youth SRH. • Youth feel they can be a “friend”. • Gender sensitive – do not treat boys and girls differently in terms of respect, privacy access and confidentiality, while acknowledging the important differences girls and boys face and addressing these differences and their concerns accordingly. • To never get angry with clients who are not clean. • “All staff should be friendly from professionals to cleaners” (Nepal).
<p>Health Facilities</p> <ul style="list-style-type: none"> • Separate space or special times set aside • Convenient hours and location • Adequate space and sufficient privacy • Comfortable surroundings. 	<ul style="list-style-type: none"> • Adolescent/Youth (A/Y) adapted opening hours (Viet Nam, Nepal). • Opening hours that are convenient for A/Y (Nepal e.g. some were open on Sundays). • Convenient location (e.g. near to schools). • Separate registration for A/Y, with or without names, but not easily accessible by others. • Privacy (sometimes meaning a separate room/space behind a curtain or true confidentiality). • At the least a counselling room and a small examination room available. • An entrance separated from the adult one was preferred. • “Attractive decoration” (e.g. posters made by young people and services given a name such as “whispering of the young grass” (Viet Nam); “colourful and clean” (Nepal). • Changes in interior – rooms decorated, pastel colours and posters designed by young people. • Outside the YFCs a signboard is visible announcing the kind of services being offered.
<p>Programme design:</p> <ul style="list-style-type: none"> • Youth involved in design, service outreach and delivery • Continuing feedback • Drop-in clients welcomed or appointments arranged rapidly • Affordable fees • Publicity and recruitment that informs and reassures youth • Boys and young men welcomed at services • Wider range of services available • Necessary referrals available 	<p>Orientation to clients’ wishes and rights:</p> <ul style="list-style-type: none"> • Client’s right to receive accurate information and best services (Viet Nam). • Clients can trust us and believe in our confidentiality (Viet Nam, Nepal). • Clients must feel welcome (Viet Nam, Nepal). • “That they are satisfied” (Viet Nam) “Make clients satisfied after counselling” (Nepal). • “Referral according to desire of clients” (Viet Nam). • Clients can discuss SRH problems openly (Nepal). • Accessible, affordable and acceptable (Nepal). • Availability of youth friendly staff (Viet Nam, Nepal).
<p>Other possible characteristics:</p> <ul style="list-style-type: none"> • Educational materials available on site and to take away • Group discussions available • Avoid unnecessary pelvic examination and blood tests. • Alternative ways to access information counselling and services 	

⁵⁰ www.unfra.org/swp/2003/english/ch5/page 3.htm



TRAINING

Training on YFHS provision has been an important focus in all the RHIYA countries; many of the countries have successfully adapted tried and tested youth training materials to their own context. Often one of the implementing NGOs took lead responsibility for developing training materials and the training model. In Bangladesh, Viet Nam and Nepal, MSI assumed a major role in providing technical assistance to develop the materials. Training for staff included addressing topics around physical space, human resources, management and marketing, data collection and gender, counselling, life skills and gender-based violence. RHIYA partners were careful to ensure that best practices and national standards were integrated into training materials. The training of trainer's model was most often used, with master trainers being prepared and trainees subsequently selected from public, private and NGO providers.

Despite training, some health workers did not feel comfortable providing services for young people – ‘a values clarification exercise’⁵¹ may be an important tool to help service providers to identify whether they are suited to providing services for the young. In the Cambodian RHAC clinics, the youth were encouraged to ask for staff by name, so they could develop and maintain a relationship with a ‘named provider’. The RHAC staff said that, while all their health workers are trained to provide youth friendly services, some were more suited to providing these services and so tended to specialize in youth service provision. However, this is more difficult in a small clinic where there are limited staff.

QUALITY ASSURANCE

“[The clinic is] good. It keeps the visit confidential, which is good for people with STIs so that they don't feel shy”
(Nepal)

Follow-up and support of clinical staff was ongoing and supported by the introduction of quality assurance models in all the project sites. Often the model was adapted from the Client Oriented Provider Efficient (COPE) model pioneered by Engender Health. Clinics monitored the quality of their youth friendly services through client exit interviews, and in some cases mystery clients. The results from country data demonstrated that for the most part youth were satisfied with the services, with consistently high scoring for perceived quality of care.

Client exit interviews conducted by the UPSU staff in Cambodia, in 2004 and 2005, demonstrated that young people were very satisfied with the services in terms of youth friendliness, attitude of staff and cost.

In Nepal, all endline survey respondents stated their satisfaction with clinical services; staff maintained confidentiality; and services were at an affordable cost:

“This is a counselling centre for young people, where young people can talk freely about their problems, for example pregnancy and STIs”

“It's affordable”

Overall, client satisfaction ranged between 98% and 100% – when asked a range of questions with regard to their satisfaction with the services and perception of the youth friendliness of the youth centre. However, youth expressed their dissatisfaction regarding how they were treated by the service provider. Many of the stakeholders mentioned how important it was to match the service provider with the target group. Some service providers have difficulties providing services to young people, for instance in Bangladesh it was noted that sometimes the language doctors use is not accessible to young people.

⁵¹ To encourage service providers to clarify and explore their personal attitudes and values and to become comfortable with listening to, and understanding, opinions different from their own; and in deciding their own suitability to provide services to young people

ACCESS ISSUES AND UTILIZATION

“The services provided at the youth clinic are friendly. They provide warm, welcome and good services, which encourage us to go back there” (Lao PDR)

There are potentially many barriers preventing young people from accessing services. In Lao PDR, a survey found the main barriers to accessing services were shyness, time constraints, monetary problems as well as a lack of information on service facilities. These barriers are apparent in the following quotations from stakeholder interviews:

“Shyness to discuss issues with friends and doctors...”

“No time to see doctors”

“Youth cannot afford the service because they send money home to families and they don’t have money to see doctors when they have STIs”

“No access to sexual and reproductive health information and don’t know where to ask for help”

ADDRESSING OPERATIONAL BARRIERS

In response to the above issues, implementing partners across the RHIYA countries tried to address operational barriers in the following ways:

Cost – can be a significant barrier to young clients. The issue of cost was mentioned time and again in discussions with stakeholders. During the programme, many of the projects heavily subsidized treatment costs and often peer educators were treated free of charge as part of their incentives package. Many of the clinic staff said that they were either still subsidizing costs and would not be able to continue to do so, or that they had been forced to start increasing fees. Where fees had been increased or free services for peer educators had stopped, both young people and clinic staff said this had impacted on utilization. This contradicts global studies, however, which have shown that young people are willing to pay for services and that they place less value on free services⁵².

Opening hours – substantial efforts were made to ensure that services were available at a time that most suited young people. In Nepal, SDPs were open on a Sunday, while in Viet Nam clinics were open out of school hours. Other clinics set times for young people beyond regular clinic hours. Often separate hours were designated for girls and boys; in Bangladesh, the clinic provided three sessions for boys and three sessions for girls. Drop-in clinics allowed for young people to access services more easily. Waiting for appointments was an issue for young people and therefore clinic staff tried to ensure they could access services without an appointment.

Location – many facilities were provided in the main urban locations, which were often easy for youth to access. In addition, mobile services for rural youth and street children increased opportunities to obtain services. A clinic was established in a squatter area in Phnom Penh to attract street children and newly migrated rural youth. Services were available in clinics within the factories to ensure young women working in them had access to services.

Confidentiality and privacy – these were important considerations. In Lao PDR and Viet Nam, no registration or names were taken at the clinics. In Cambodia, the RHAC clinic maintained privacy by having different entrances for adults and youth. In addition, different treatment areas and medicines were provided without having to go to the general clinic dispensary.

Community perceptions – were often cited as barriers to using services; advocacy activities continued throughout the project to ensure that communities were supportive of the youth health facilities.

⁵² Senderowitz J. (1999) Making Reproductive Health Services Youth Friendly. Focus on Young Adults Research. Program and Policy Series

Addressing quality and providing youth friendly services was not a guarantee that they would be utilized. Each project conducted promotional activities to increase utilization. Activities included ‘word of mouth’, radio slots, peer education and outreach activities. Staff working in public facilities felt that there was a need for adolescent and youth services despite the fact that actual utilization of clinical services by the target groups may have been quite low. Public facilities were less able to promote their facilities than NGOs, who had staff and allocated funds for such activities. In addition, it was difficult to change perceptions of public services that had not previously been youth friendly.

In Lao PDR, respondents to a RHIYA survey stated that the services at the youth centre were good, friendly and totally different from the services provided at hospitals.

“Some service providers are friendly, but some are not”

“The youth clinic is friendly, and the services are good”

“The services at our youth clinic are better and friendlier than those at the hospitals”

“Good service, quick work, good care and we feel welcomed there”

“[At the hospitals] the services are slow and we have to wait for a long time”

REFERRAL NETWORKS

“Young people are shy to go see a doctor at a hospital. Besides, they do not think that health issues are important”
(Cambodia)

As previously mentioned, when services in youth friendly clinical facilities were limited, referral networks were established. These networks required constant maintenance due to staff changes. Referral mechanisms were set up, which included referral forms and staff phoning named contacts at the referral centres. In Cambodia, when referral was to a government clinic, NGO staff would accompany the children; this was necessary as sometimes staff would not allow street children into the clinic and the children had difficulty asking for the agreed discounts. Staff stated that youth were often reluctant to be referred from one facility to another. However, if staff were able to reassure them of the quality of the referral centre, they were willing to attend.

What next?

As the RHIYA programme closes and policymakers and planners consider ‘what next?’ there is much to be learned from the RHIYA experience. The RHIYA programme provided a range of services for young people and demonstrated many gains in SRH related indicators as a result. This stakeholder review has highlighted many innovative approaches to service provision and a number of key considerations that future programmes should take into account; these include:

- Youth involvement in designing, implementing and monitoring services is essential.
- Systematic needs assessments, in particular mapping of vulnerable groups, help to focus services more effectively and can be an entry point to ‘less visible’ youth.
- A flexible programming approach, which encourages innovative, tailored and holistic service provision for young people, is required.
- More sensitive monitoring approaches should be developed, which allow better attribution of success to individual programme components.

Despite the short timespan of the RHIYA programme, survey findings demonstrated progress in improved knowledge and behaviour. However, short-term programming solutions need to be replaced with longer-term strategies, which allow ample time for operational research to be conducted and good practices to be scaled up.



Appendices





Appendix 1 – Country-specific models of YFHS

This section reviews the models of YFHS utilized in five of the 7 RHIYA countries, where YFHS were an important feature of the programme.

BANGLADESH

An integrated approach has been developed, including advocacy at community-level with parents and community gatekeepers; peer education and development of youth resource centres to increase knowledge and skills; and youth friendly service provision in existing clinics. Services are predominately provided through NGO-run clinics, with some differentiation of services for young people through special opening hours, separate clinic entrances etc.

YFHS models used in Bangladesh

ORGANIZATION	TARGET GROUP	CATCHMENT	KEY STRATEGIES
Family Planning Association of Bangladesh (FPAB) – Health lifestyles for urban adolescents and youth (9 sites)	Urban and peri-urban adolescents and youth	Cox's Bazaar	Peer educators mobilize youth to use services youth friendly counselling and clinical services, youth resource centres - All NGO clinic based
Red Crescent Society (BDRCS) – Strengthening community linkages for youth in SRH services	Urban and Peri-urban youth	Dhaka and Sylhet	Peer educators, youth resource centres, clinical services at NGO SDPs/hospitals
Marie Stopes Clinic Society (MSCS) – Better SRH services for urban adolescents and youth	Urban adolescents and youth	Areas around MSCS clinics	Peer educators, youth centres and clinical service provision – All NGO clinic based
Concerned Women for Family Development (CWFD)	Urban adolescents and youth (garment factory workers)	<ul style="list-style-type: none"> • Dhaka • Khulna • Gazipur • Narayn • Gonj • Tangail 	Peer educator, youth resource centres and clinical services provided at NGO SDPs

CAMBODIA

The Reproductive Health Association of Cambodia (RHAC) integrated youth friendly sexual and reproductive health services into their existing NGO SRH clinics in urban and semi-urban centres. In addition, they support training in youth friendliness for public health care providers. CARE target factory workers in urban areas, many of whom have migrated from the provinces. Nurses at the emergency health unit in the selected factories are equipped with knowledge and skills to cater for the information and service needs of young workers on SRH-related issues. The FRIENDS project in Phnom Penh specifically targets young people who live or work on the street.

SRH services including counselling are provided through their static clinics, mobile services and drop-in centres, while SRH-related information and education are integrated in their various shelter and skill-building programmes. The health centres receive many clients referred through the Mith Samlanh/FRIENDS network. The network includes providers at Chamkar Mon Health Centre (a government health centre) in Phnom Penh where Voluntary and Confidential Counselling and Testing (VCCT) services are available.

YFHS models implemented in Cambodia

ORGANIZATION	TARGET GROUP	CATCHMENT	KEY STRATEGIES
FRIENDS 'Building on experience'	Urban marginalized/vulnerable youth – street children	Phnom Penh	<ul style="list-style-type: none"> Peer educators as referral agents SRH service delivery through basic health care facility, mobile services + referral Integration of SRH in skills building and shelter programme
RHAC Cambodia Adolescent RH Project	Urban and rural youth	4 SRH clinics and outreach programmes in Phnom Penh, Takeo and Kampong Cham provinces	<ul style="list-style-type: none"> Peer educators Integration of A/YFSRH services at existing NGO SRH clinics Youth resource centres within the RHAC clinics Development of public health centre facilities for youth through training of health workers
CARE, PFD – Playing Safe and Sewing a Healthy Future	Youth working in garment factories and rural youth	Phnom Penh, Koh Kong and Kratie	<ul style="list-style-type: none"> Peer Educators Integration of A/YFSRH services into existing government health centres of which focus is primary health care Setting up a youth centre near the health centre to serve as an entry point

Lao PDR

In Lao PDR, models developed for urban and rural youth differ. In Vientiane, urban adolescents and youth have access to a static clinic service specifically set up for young people. In addition, this clinic provides services for more vulnerable youth. The clinic situated behind the Women’s Union Youth Centre provides a confidential youth friendly service, staffed by specifically youth friendly trained staff. In the rural areas, a mobile outreach unit provided YFHS. Both models were provided by NGOs, although referral networks with public services were established and functioned well.

Implementation models in Lao PDR

ORGANIZATION	TARGET GROUP	CATCHMENT	KEY STRATEGIES
<p>Women’s Union Vientiane Youth Centre for Health and Development</p> <p>Linked with Peer Education among Vulnerable Youth – CARE International</p>	<p>Urban youth, including youth working in bars and commercial sex workers</p>	<p>Vientiane</p>	<p>Peer education, life skills training, confidential counselling and youth friendly clinical services and referral for more comprehensive SRH services.</p>
<p>Health Unlimited and Lao PDR Youth Union – Adolescent SRH Outreach in selected villages in southern provinces</p>	<p>Rural youth</p>	<p>6 districts of Saravan, Sekong and Attapeu, in the three southern most provinces of Lao PDR</p>	<p>IEC through radio and peer education – mobile outreach continued to be an important activity of the project, which conducted to village-based outreach activities consisting of SRH IEC for young people, family planning and medical services.</p>



| 46 CARE: Peer educator, Lao PDR

NEPAL

In Nepal, the NGOs have set up both YICs and youth friendly service delivery points (YFSDPs). Some of these services are provided by NGOs, others are based on referral to public health facilities.

Implementation models in Nepal

ORGANIZATION	TARGET GROUP	CATCHMENT	KEY STRATEGIES
BP Memorial Health Foundation – Better Information for Young People Programme	Urban and rural adolescents and youth	10 Village Development Committees (VDCs): Ageuli, Nayabelhani, Tamsariya, Prasuni, Kumarwanti, Shivamandir, Kawasoti, Pithauli, Pragatinagar and Rajahar of Nawalparasi	<ul style="list-style-type: none"> Peer education, supporting youth friendly clinical services in public facilities. Telephone counselling service in Kathmandu valley (Kathmandu, Lalitpur and Bhaktapur three districts).
Family Planning Association of Nepal (FPAN)	In and out of school 10-24 years of age in urban and rural areas, vulnerable youth	30 villages, 5 programme districts: Kailali and Kanchanpur in far west, Dang in mid-west, Dhanusha and Kavre in the central development region of Nepal	<ul style="list-style-type: none"> NGO YFSDPs providing SRH services to young people including distribution of condoms (without registering client names), SRH counselling as well as laboratory services. YICs for both in and out of school adolescents and youth.
PHECT – Nepal Public Health Concern Trust – “Improving SRH & Reducing Gender-based Violence among Adolescent and Youth”	In school (10-24) & out of school (12-24) underserved communities Tamang, Kami, Thami & Damai	Suspa, Chhyamawati, Sundrawati, Lapilang and Lamidanda VDCs in Dolakha district	Counselling, NGO YFSDPs and YICs, referral to public facilities
Samjhauta Nepal Empowering Youth through Life Skills and SRH Education through the 6 local implementing partners NGOs	Rural youth	Bara, Mahottari and Dhanusha districts	<ul style="list-style-type: none"> Peer education, youth information centres in private houses and YFSDPs – one in government health offices Counselling provided although not able to provide full range of clinical services
Sunaulo Parivar Nepal Improving Utilization of SRH Services by Adolescents & Youths in Nepal	Rural youth	4 districts (Jhapa, Parsa, Chitwan and Banke) 1 municipality and 19 VDCs	Peer education, outreach and NGO Clinics

VIET NAM

In Viet Nam, VINAFPA was the executing agency for a number of strong national NGOs providing clinical YFHS. The NGOs worked closely with public health facilities and many of the projects have supported public facilities to become youth friendly, through training and provision of equipment.

Implementation model in Viet Nam

ORGANIZATION	TARGET GROUP	CATCHMENT	KEY STRATEGIES
Viet Nam Family Planning Association (VINAFPA) Centre for Reproductive and Family Health (RaFH) Viet Nam Association of Midwives (VAM) Marie Stopes International (MSI)	Urban adolescents and youth	Hanoi Hai Phong Ho Chi Minh City Hue DaNang Hoa Bin Khanh Hoa	Peer educators, youth resource centres, mobile services to schools and factories, social marketing, NGO and public clinic services.



47 Preparing group work, advocacy workshop, Viet Nam

Appendix 2 – youth services tool

YFC TOOL – AREAS OF DISCUSSION	PROMPTS	INFORMANT RESPONSES
Conception phase		
Why did you introduce youth services?	E.g. Was it based on a barriers assessment?	
What was your target group?	E.g. Age, gender, out of school/in school, urban/rural? Do services cater for unmarried youth?	
What did you want to achieve through providing youth services?		
What is your definition of 'youth friendly'?		
Implementation phase		
Types of services provided	<p>What kind of strategy did you employ? I.e. using existing services/private providers, government/NGO clinics?</p> <p>What kinds of services were provided? I.e. counselling/ clinical?</p> <p>Agreements in place with partners – Public/private partnerships?</p> <p>Location of services – e.g. urban/rural & library/health centre/ clinic</p> <p>Who is using the services?</p> <p>Did you integrate gender sensitive approaches? If so how? I.e. female staff for female clients?</p> <p>What were the key constraints faced in the provision of services and how did you overcome these? E.g. Cost.</p> <p>What type of services were most in demand? E.g. counselling/ clinical services</p> <p>Were youth involved in designing youth friendliness of services?</p>	
Referral Mechanisms		
What referral mechanisms were put in place?		
How did you prepare facilities for receiving referrals?		
Creating demand for services		
How did you create/ promote demand for services?	<p>Were services provided free of charge?</p> <p>What type of promotional activities did you employ to attract youth?</p> <p>Did you carry out outreach activities aimed at promoting demand for services?</p>	

YFC TOOL – AREAS OF DISCUSSION	PROMPTS	INFORMANT RESPONSES
Training approaches and supervision		
What type of training and supervision was provided to staff?	How did you select staff to train in youth friendly service provision? I.e. topics used for training/duration/ refresher/ training methods and materials What type of training is used? What type of supervision/support was provided to staff? I.e. topics used for training/duration/ refresher/training methods and materials Did training include values clarification?	
Quality of services		
	How did you monitor quality of services? (qualitative) Did youth come back to use the service more than once? Type of staff providing the services? Were youth friendly trained staff available at all times? Reputation of services within the community? How was confidentiality maintained?	
Effectiveness of Services		
How effective were your services in achieving your objectives?	Could you have used another approach to achieve the same objectives? What adaptations did you make to the youth services during implementation, and why? Do you think your youth services have been successful in the eyes of the community, peers etc? And in what sense? What would you do differently programmatically?	
Sustainability and cost effectiveness		
Do you think youth services can be sustainable?		
Cost effectiveness	What % of your budget is allocated to youth friendly services? How much money does this represent?	
Constraints / Facilitating factors		
What were the constraints in providing youth services?		
What were the main facilitating factors?		

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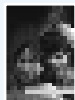
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For further copies, contact: UNFPA RHIYA Central Unit, Rue Montoyer, 14, 1000 Brussels, Belgium
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