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PROGRAM BRIEF

PSI'S SEXUAL AND REPRODUCTIVE HEALTH PROGRAMS FOR YOUTH



USAID
FROM THE AMERICAN PEOPLE



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For more information about this program brief contact:

Rena Greifinger
1120 19th St., NW, Suite 600
Washington, DC 20036
rgreifinger@psi.org

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To access the capabilities of SIFPO, USAID missions and bureaus can buy into the cooperative agreement.

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POPULATION SERVICES INTERNATIONAL (PSI)
1120 19th Street, NW, Suite 600
Washington, DC 20036

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MEET YAMIKANI



Yamikani is a 15-year-old student in Malawi finishing Standard 8 this year. She is the second of five children comprised of two boys and three girls. Her mother, Chrissie, aged 34, sells vegetables at the market and her father, Samuel, aged 38, owns a bicycle repair shop.

After school in the afternoon, Yamikani helps her mother in the market and watches her younger brother and sister. Her boyfriend, Miky, is 19-years-old and a leading soccer player on the local team. In her free time, Yamikani likes to watch soccer games and chat with her girlfriends. On Sundays, she attends church with her family. When she finishes Standard 8, Yamikani hopes to get a place at Ntcheu Secondary School. Someday she would love to be a nurse and work at Ntcheu District Hospital or move to Lilongwe and work there.

Yamikani and Miky have been dating for two months. Recently, Miky gave Yamikani a phone for a gift; now she feels obliged to have sex with him. She's not sure if she's ready, and a few of her friends have gotten pregnant. Many were dating older men and received nice gifts too. Yamikani really wants to finish school and transition to secondary school but is afraid that she might get pregnant. She knows that there are pills a girl can take to prevent pregnancy, but she's worried that Miky will think she's promiscuous if he finds out.

This program brief is dedicated to all of the Yamikanis of the world.

ABBREVIATIONS AND ACRONYMS

ABMS	Association Béninoise pour le Marketing Social
AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
EDC	Education Development Center
FP	Family Planning
GIGI	Got it? Get it?
HIV	Human Immunodeficiency Virus
IPC	Interpersonal Communication
IPPF	International Planned Parenthood Federation
NGO	Non-Governmental Organization
PRB	Population Reference Bureau
PASMO	Pan American Social Marketing Organization
PSI	Population Services International
RH	Reproductive Health
SIFPO	Support for International Family Planning Organizations
SRH	Sexual & Reproductive Health
STI	Sexually Transmitted Infections
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
YFHS	Youth-friendly Health Services
YMCA	Young Men's Christian Association

INTRODUCTION

Today, over 1.8 billion young people between the ages of 10 and 24¹ inhabit the world, 90% of whom live in developing countries (USAID, 2012). In sub-Saharan Africa, nearly one in three people, or roughly 300 million, are between the ages of 10 and 24. By 2050, that number is projected to reach 561 million (Clifton & Hervish, 2013). Young people in developing countries die from disease at a significantly higher rate than their peers in developed nations. For instance, less than 1% of 15-year-olds in developed countries die before their 25th birthday. In South Asia, the odds of dying before age 25 are nearly twice as high; in sub-Saharan Africa, these odds quadruple (UN, 2011). To concentrate solely on these disparities, however, does not give a complete picture. Today's young people are better educated than previous generations and their access to new technology and social and professional networks is growing. They are optimistic about the future, set high expectations for themselves, and are proving to the world that they can and must be part of the global discourse on reaching development indicators. While gaps in evidence, limited resources, and unpredictable levels of political will can make our work difficult, we are nonetheless at a critical point in time to harness the energy and optimism that young people bring into the world and engage them in research, programs, and advocacy initiatives that will support their growth into healthy adults.

In recent years, the global health community has shifted its perception of young people, viewing them not as problems that need to be solved, but as participants in the solution-making process. Evidence of this shift can be found in key highlights from U.S. government and multi-lateral agencies:

UNFPA's State of the World's Population: Motherhood in Childhood (2013): Focuses on the challenge of adolescent pregnancy across the world.

USAID's Youth in Development Policy (2012): Places strong emphasis on integrating youth considerations as cross-cutting factors in all USAID programming – health, education, and economic empowerment.

Bali Global Youth Forum Declaration (2012): Recognizes young people's rights and explicitly states the need for investments in young people's sexual and reproductive health (SRH) to achieve Millennium Development Goals.

Ending Child Marriage and Meeting the Needs of Married Children: Vision for Action (2012): USAID's commitment to preventing and responding to gender-based violence as part of its development and humanitarian assistance mission.

UNICEF's State of the World's Children: Adolescence, an Age of Opportunity (2011): Advocates for large investments in adolescents, given historical global gains achieved in early and middle childhood since 1990.

Yet, despite the increasing number of policies and programs focusing on young people, their SRH needs remain severely underserved. High levels of unmet need for contraception, unintended pregnancy, maternal death, and HIV and sexually transmitted infections (STI) are just the beginning. Significant barriers exist across many socio-ecological strata – young people lack the knowledge and skills to access health services; providers are unwelcoming and judgmental of young people; restrictive

1. For the purpose of this program brief, the terms "youth" and "young people" will be used interchangeably to refer to those between the ages of 10 and 24. The majority of PSI services, however, reach youth between 15 and 24 years old.

WHY WORK WITH YOUNG PEOPLE?

- Nearly half of the world's population is under age 30 (USAID, 2012).
- Every day, 20,000 girls below age 18 give birth in developing countries (UNFPA, 2013).
- In developing countries, 90% of births to adolescents (10-19) occur within marriage (UNFPA, 2013).
- Maternal mortality is 28% higher among 15-19 year olds than 20-24 year olds (Nove et al., 2014).
- 70,000 adolescents die annually of causes related to pregnancy and childbirth (UNFPA, 2013).
- The majority of sexually active young people in Sub-Saharan Africa do not use a modern method of contraception (Guttmacher and IPPF, 2010).
- Nearly half of all HIV infections and 70% of STIs occur among 15-24 year olds (UNAIDS 2012).

policies limit young people’s contraceptive choices; and deep-seated cultural and gender norms create barriers to information and services. Promising approaches address these barriers comprehensively, and meaningfully engage young people in the design, delivery, and evaluation of programs.

Population Services International’s (PSI) SRH Programs for Youth

Population Services International (PSI) is a global health organization dedicated to improving the health of people in the developing world by focusing on serious challenges like lack of family planning (FP), HIV/AIDS, barriers to maternal health, and the greatest threats to children under five. PSI is committed to the principle that health services and products are most effective when they are accompanied by robust communications and distribution efforts that help ensure wide acceptance and proper use. As a global leader in social marketing² and social franchising³, PSI draws on its expertise to deliver high quality services, products, and communication to achieve large health impact among young people. PSI uses a comprehensive approach to reach young people through a diverse set of programs in dozens of countries. PSI is dedicated not only to scale its own programs, but to build the entire market for products, behaviors and services that will result in positive health outcomes for young people. This Total Market Approach⁴ contains three broad, distinct areas: 1) Service delivery interventions, 2) Behavior change communication (BCC) interventions, and 3) Structural interventions. Depending on the country and the program, PSI can flexibly implement this approach in one, two, or all three areas. Programs are then tailored for different groups of young people (e.g., in-school vs. out-of-school youth, married vs. unmarried girls, youth from key populations, etc.) depending on the location and context.

PSI’s Approach to Youth Programming

In light of USAID’s Youth in Development Policy released in 2012, and with support from the USAID funded Support for International Family Planning Organizations (SIFPO) project⁵,

PSI has re-evaluated and updated its tools, guidelines, and program design efforts for youth programming to better align with international best practices and global priorities. The following pages provide a brief overview of key programs that PSI is implementing to improve the SRH of youth around the world.

CHARACTERISTICS OF PSI’S YOUTH-FRIENDLY SERVICES*

- Providers and staff have received training to work with youth, communicate with youth, and understand their own values regarding youth, sex, and SRH.
- All members of staff communicate with youth in a respectful and nonjudgmental manner, regardless of age, gender, sexuality, or marital or health status.
- The service delivery site has confidentiality and privacy policies.
- The site is open during convenient hours and accessible for young people.
- The facility markets its services to young people in “youth spaces.”
- Efforts are made to create a youth-friendly environment.
- Fees are affordable for those who may be in school, not working, or earning little.
- Drop-in clients are welcome, and appointments are arranged rapidly.
- Youth participate in developing, implementing, and evaluating policies and services.
- Community members and influential leaders are aware of the health-service needs of different groups of youth and support their provision.
- A minimum package of services is provided on-site or through referrals to other youth friendly services.
- A system for referring clients is in place.
- The site has copies of the national youth policy and YFHS standards, tools, and job-aids (if they exist).

* These characteristics assume that basic quality assurance standards for SRH services and care are already in place.

Summary Checklist from PSI’s Guide to Strengthening Youth-Friendly Health Services

- 2 Social marketing applies marketing principles and techniques to change the behaviors of target audiences for social good. PSI’s social marketing approach to improve public health is two-fold: create markets in developing countries for impactful health products and services and use social marketing to promote their adoption.
- 3 Social franchising applies commercial franchising strategies to the non-profit health sector to efficiently expand access to higher quality health care that is affordable to underserved communities. Social franchising works by creating a network of health care providers that are contractually obligated to deliver specified services in accordance with franchise standards under a common brand. Social franchising improves access, quality, equity and cost-effectiveness of health service delivery via the private sector.
- 4 Total Market Approach aims to make markets work for poor and vulnerable consumers by increasing coverage of those in need while simultaneously improving overall market equity and efficiency. Over the longer term, TMA aims to reduce the subsidy required to ensure convenient access to and consistent use of essential health products and/or services; by targeting subsidized market inputs, TMA increases opportunities for commercial contributions to total market growth.
- 5 Cooperative Agreement No. AID-OAA-A-10-00030, Support for International Family Planning Organizations

Service Delivery Interventions

Studies have shown that the most common barriers young people face in obtaining services for contraception are social stigma (e.g., fear or embarrassment) and providers' attitudes (Advocates for Youth 2002; Zuurmond et al, 2012). Other barriers include low levels of knowledge and/or misconceptions about contraception, high cost of services, crowded waiting rooms, lack of confidentiality and privacy, inconvenient opening hours, little or no accommodation for walk-in patients, limited contraceptive supplies and options, and lack of knowledge about where to go for services (Biddlecom et al, 2007).

As of 2013, all of PSI's social franchise standard operating procedures include guidelines for integrating youth-friendly service provision. Several PSI country programs have long been providing youth-friendly services and their experiences have helped inform other programs. PSI programs in the Caribbean, Liberia, Haiti, Malawi, and Burundi are planning to establish new social franchise networks in their respective countries that will be using the newly developed standardized social franchising tools, which were created to include youth-friendly components, to encourage and increase SRH service utilization.

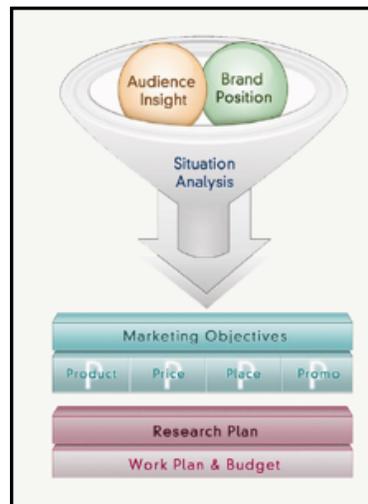
In June 2013, PSI piloted its new guide, *Making Your Health Services Youth-Friendly*, in Malawi in a two-week capacity building exercise that included a six-day training for private sector health care providers in youth-friendly service provision, and a three-day training of trainers and work planning session for PSI Malawi staff. The goals of the training were to introduce global and country-level definitions of youth-friendly health services (YFHS), explore providers' personal and professional values related to providing SRH services for young people, and to then practically apply assessment and planning tools to strengthen gender and youth-friendly services across PSI Malawi's social franchise network. PSI is currently rolling out similar in-person training sessions in Liberia, with both public and private sector providers, and in Uganda in late 2013 and early 2014, respectively. Virtual training sessions through a web-based Reproductive Health Leadership Series for PSI field-based staff are also being provided.

In early 2014, PSI will publish and disseminate the *Making Your Health Services Youth-Friendly* guide.

Behavior Change Communication Interventions

PSI is a leader in behavior change communication programs

tailored to specific groups to encourage health-seeking behaviors. PSI's BCC uses commercial marketing techniques to position products and services with messages that promote knowledge and help normalize and reinforce healthy behaviors. Campaigns are disseminated to target audiences through a variety of channels – such as mass media, peer education, school programs, community-theater, mobile multi-media events, interpersonal communication, and special event sponsorship – and are presented in many ways so that those with various levels of education can benefit.



Successful social marketing requires insight, analysis, and solid evidence-based decision making. This idea is embodied in PSI's DELTA marketing planning process. This process was created to ensure that insight into our target group is optimally utilized when planning intervention activities, and to create a seamless flow from epidemiology to audience

profile, to strategy. DELTA also ensures consistency across all decision-making, by framing execution within an established positioning for the product, service, or behavior, which, in turn, increases the efficiency and effectiveness of health decisions. The DELTA process contains seven steps:

1. **Situation Analysis** analyzes the context in which the intervention takes place to ensure that the most appropriate target group and behavior is selected, and to identify strategic priorities for the marketing plan. PSI uses quantitative and qualitative research in order to prepare the Situational Analysis.
2. **Audience Insights** are then created by using the Situational Analysis as a framework. Audience Insights "bring alive" the target group with a vivid picture of their lives and values. They give the target group a persona, with a face, a name, aspirations, and desires. Audience Insights are used to create audience profiles like Yakamani from Malawi.
3. **Brand Positioning** is everything that the audience knows and believes about the product, service, or behavior. This is the emotional "hook" upon which one can hang the

marketing strategy.

4. **Marketing Objectives** specify the goals of the program.
5. **The Four Marketing “P’s”** – Product, Price, Place, and Promotion – specify what strategies will be used to achieve the marketing objectives.
6. **The Research Plan** details how the intervention will monitor and evaluate implementation of the plan, as well as identify and prioritize any information gaps about the target group and how they will be explored.
7. **An Integrated Budget and Work Plan** is then developed to specify how financial resources will be allocated among the “4P’s” and to help managers allocate human and other resources and to monitor implementation.

External evaluations examining the effectiveness of social marketing programs targeting youth have found that these programs reached a higher proportion of youth than did other programs working in a similar context (e.g., see study of PSI/Cameroon’s (ACMS) 100% Jeune program, Plautz & Meekers, 2003).

Structural Interventions

COMMITMENT TO YOUTH INVOLVEMENT

PSI is committed to meaningful youth involvement at all stages of the program process – design, delivery, and evaluation. When designing youth campaigns and programs, PSI invites local young people to take part in DELTA planning, formative research, and at times, in the role of a youth advisory board. Young people play a strong role in program implementation – as radio hosts, magazine publishers, peer educators, and community mobilizers. Young people support quality assurance assessments of youth-friendly services and take part in evaluation research to ensure the success of PSI programs.

PSI’s approach to public health rests on the understanding that in addition to providing services and changing behavior, we also must address the social, economic, legal, and cultural factors that shape the health problems we work on. These “structural factors,” although beyond the control of individuals, influence the environment in which people live, creating health problems for whole populations (Hargreaves 2013). These same factors

tend to exacerbate inequities in populations, particularly gender inequity.

PSI is committed to promoting gender equality, challenging negative gender norms, and ensuring that our programs, services, and approaches are gender equitable. To accomplish this, we began with a thorough review and edit of PSI’s key documents and approaches, such as the DELTA marketing planning guide and the Quality Assurance manual for Health Services. In countries like Papua New Guinea, Swaziland, and Zimbabwe, PSI staff teams have undergone gender awareness training, in order to design more effective gender equality programs. These teams have also developed BCC campaigns to challenge negative gender norms that drive the gender-based violence epidemics in these countries.

Stigma is also a structural factor that creates significant barriers for much of PSI’s work. Stigma related to sex, sexuality, and sexual health, on the part of young people, their families, their providers, and their surrounding communities, is a significant reason that young people do not seek health services, use contraception, or test for HIV and STIs. In Central America, PSI’s affiliate, the Pan American Social Marketing Organization (PASMO), is trying to address this stigma through a radio program, as part of Club en Conexión, which provides young people aged 10-24 with access to information about reproductive health (RH), HIV, and STIs. The program hires and trains young people themselves to reach other young people with information and positive messages about sex and sexual health.

PSI is also committed to international and in-country advocacy efforts that support an environment that enables young people to access high quality sexual health products and services. PSI/Washington provides an intensive week-long advocacy training that helps country teams design new or strengthen existing communication campaigns to drive government policy change. PSI also plays a leadership role on the Youth Health and Rights Coalition, and the Coalition for Adolescent Girls.

PROGRAM HIGHLIGHTS

The following section highlights program examples from the field. All of the programs use a combination of the strategies highlighted above, stemming from an audience profile developed for the target youth audience.

Cameroon

PSI/Cameroon's (Association Camerounaise pour le Marketing Social) 100% Jeune uses mass media campaigns (TV and radio ads and posters), peer education, weekly radio shows, an 18-episode radio series, and a magazine to reach at-risk youth with information about HIV prevention and SRH. The program worked with condom sale outlets to train them to become "youth-friendly providers," by attracting young people and providing them with information and condoms. 100% Jeune also built the capacity of health centers to provide services that are equitable, accessible, appropriate and acceptable to young people. Since 2000, the program has reached over four million youth.



Benin

Meet Jolie: *Jolie is 17 years old. She is in 11th grade and likes going to school to see her friends, but doesn't like to study much. She's a romantic and likes to listen to soft music, read novels, and hang out at the beach. Jolie knows that condoms are a way of preventing unintended pregnancy and STIs. Jolie avoids unprotected sex; condoms give her the confidence that she is protecting herself and her honor. However, getting condoms can be a challenge. If she buys condoms, her friends will think she's*

"ruined," and her family will think she has rejected their values.

Amour&Vie

Benin is a small country with a large share of adolescents; 23% of the population is 10-19 years old. Data from the Demographic Health Survey estimates that 61% of Beninese youth ages 15-25 are out-of-school, and nearly one-in-four women ages 20-24 give birth before the age of 18. PSI/Benin has one of PSI's largest youth programs and aims to reach in-school and out-of-school youth in urban and hard to reach rural areas. In 1996, the Association Béninoise pour le Marketing Social (ABMS), the local PSI affiliate, established a magazine, *Amour&Vie*. The magazine is distributed to 11-19 year olds in secondary schools for 100 CFA (20 cents). To increase its popularity and appeal to youth, the magazine displays a contemporary popular personality on the cover page. Each magazine publication produces 50,000 copies sold throughout the country. The magazine is in French, but there is a page in English, which English teachers report using for class exercises. There is also a page about activities taking place at ABMS's youth centers, which opened recently as an effort to expand ABMS' youth health services network.

Amour&Vie also launched a radio show that partners with several of the country's radio channels. Radio hosts address themes from the latest issue of the magazine. Young listeners can call the direct line – up to five or six young people in 30 minutes – to discuss these issues with specialists, such as medical providers, mothers, teachers, etc. Topics not only address SRH, but can also include hand washing, financial responsibility, malaria, and many other topics. After the discussion, radio hosts play music and usually invite a local artist to participate in the discussions. At the end, hosts read out announcements from youth seeking to meet other youth to expand their social network and build connections. Two new shows are developed each month, and each is aired several times so that a show can be played each week. Each year, four new youth hosts are recruited and trained by two hosts from the previous year.

PSI/ABMS regularly and diligently evaluates Amour&Vie media programs. In addition to collecting routine data, young facilitators from the PSI/ABMS's office conduct focus groups throughout the year with in-school and out-of-school youth to get feedback on the magazine and the radio and television shows. Each focus group lasts from 1-2 hours and answers the

following sample questions:

- Do you read the magazine? If not, why?
- What do you like about the magazine?
- What would you add, remove, or change in the magazine?
- Which topics do you prefer? Which topics would you like to see in the magazine?
- How many of your friends read the magazine? What do they think?
- Are you satisfied with the cost of the magazine?



Questions are also asked about the radio and TV shows. Responses inform program adjustments for future publications and broadcasts, as well as which topics to cover. This process ensures that programs remain fresh and relevant to young peoples' preferences and the latest trends.

PROFAM

PSI/ABMS has a well-established social franchise network called PROFAM. In March 2013, drawing on its experience in service provision and results from focus groups conducted with youth in and out- of-school, PSI/ABMS opened the first five of its 15 pilot health centers under their youth umbrella brand of Amour&Vie. The health centers primarily target in-school and out-of-school youth ages 10-24, and secondarily target men, women, and opinion leaders to create an enabling environment for SRH. These one-stop-shop centers include a wide menu of services: FP, cervical cancer screening, STI screening, HIV counseling, testing, and treatment referral, Hepatitis B screening, malaria case management, nutrition counseling, hygiene promotion, drug and tobacco prevention, and referrals to partner sites that offer entertainment and media services. Internet access and computer services like printing and scanning are available for a small fee. Given the fairly recent launch of the project, it is too soon to share relevant facts and figures for program monitoring and evaluation. However, the data collected from the first phase of the pilot will guide the launch of the next wave of centers.

Peer Education Activities

The Amour&Vie youth program employs 180 peer educators comprised of in-school youth, young people who have not completed school, and young mothers. PSI/ABMS provides an initial training on SRH topics, leadership, facilitation strategies, and school and community club management, followed by a refresher training six months later. Peer educators conduct community outreach activities in four-person teams comprised of two peer educators (one male, one female), a community counselor, and a Peace Corps volunteer. The teams, and in particular the peer educators, are monitored during their first year and receive two supervisory visits for their SRH, malaria, diarrhea, and hygiene sessions. The sessions take place outside of school hours to reach the maximum number of youth and to reinforce messaging when school is out of session, a time when risk-taking is higher. In 2012, PSI/ABMS conducted 184 sessions in 60 school clubs, reaching over 3,000 boys and more than 3,500 girls. PSI/ABMS's brand Amour&Vie is widely recognized in Benin and has been an important motivating element for sustaining branded peer education interventions. Many of the sessions cover topics from the Amour&Vie magazine, which is sold and distributed to young people throughout Benin.

PSI/ABMS uses a hotline, called Ligne Verte, to respond to youth who call in with concerns and suggestions. The hotline is open from 9 am to 7 pm Monday through Friday, and on-call counselors speak several local languages and are trained to answer questions on a variety of topics such as STIs, HIV, RH, FP, diarrhea, etc. Counselors frequently refer callers to clinics close to their location. Each call is tracked in a database to inform program improvement and monitor trends in callers' inquiries, age, gender, etc. Amour&Vie also has a Facebook page with over 5,500 subscribers.

Key to PSI/ABMS's success with youth programs has been a) significant youth involvement; b) strong partnership with Peace Corps and other local partners; c) strong brand identity; and d) a comprehensive approach that combines service delivery with BCC.



© Solomon Rogers, 2013

Liberia

Meet Fatuma: Fatuma is 17-years-old and starting 9th grade. She lives with her two older sisters, their families, and one younger brother. Both of her parents died several years ago, so she has been helping her sisters raise their brother and take care of their home. When she has time, Fatuma likes to hang out with her friends after school. Together, they like to listen to music, sing, and talk about boys. With all the work she has to do at home, Fatuma likes to relax by listening to the radio. Fatuma has never had a boyfriend, but she's had sex with two boys from her neighborhood. She did not use condoms or contraception with either boy because no one had ever talked to her about their availability. She recently learned about contraception at school and about STIs on the radio. She is afraid to talk to her sisters about sex because she does not think that they would approve of family planning since they both had their first child before 18.

A country recovering from the lingering effects of civil wars, Liberia's youth profile is quite grim. The birth rate for 15-19

year-olds is high at 177 per 1,000 live births; 38% of women 20-24 gave birth to their first child before the age of 18. The contraceptive prevalence rate is 20%.

To address these and other gaps in health information and services, including low levels of knowledge about HIV and prevention, since 2009 PSI/Liberia has been implementing a youth-led radio program called *Let's Talk about Sex*, sponsored by UNFPA. The show, broadcast in 15 counties, airs twice weekly with a live show on Thursdays and a repeat show on Saturdays. The program is complemented by sessions with youth groups who listen to the show and then host in-depth discussions about that week's topic. PSI/Liberia partners with the local YMCA to provide HIV counseling and testing and contraceptive methods at youth events such as basketball games and concerts.

At these and other events, PSI/Liberia promotes its branded condom, *Star*®, launched in 2009. *Star* is Liberia's first socially marketed condom, branded exclusively for Liberian youth ages 15-24.

HealthyActions

In 2013, PSI/Liberia launched a pilot peer education program called *HealthyActions*. The five-day curriculum is designed to reach out-of-school youth ages 13-35, and is delivered by trained health educators in alternative high schools run by the Education Development Center. The curriculum aims to build knowledge of HIV, STIs, and FP with a focus on prevention; develop condom negotiation skills and other valuable communication skills; explore values and develop critical thinking skills around access to FP; explore sex, sexuality, and HIV stigma; and to spur action to seek FP and HIV counseling and testing services.

The curriculum uses role-play activities, games, case studies, and scenarios, as well as group discussions to build learners' knowledge, skills, and confidence. As part of the USAID-funded Advancing Youth Project and Liberia's wider Alternative Basic Education Program, the program is aimed at those who missed the chance to attend formal school or complete an education because of the war or as a result of unintended pregnancy. The sessions are being held in 36 schools during the evening for three hours, and are designed for those who wish to go back to school but are too busy to attend school during regular hours. The training concludes on Saturday with a clinic celebration day where learners are connected to local clinic staff and offered

free HIV counseling and testing, FP counseling, and contraceptive methods.

In the initial phase of the pilot *HealthyActions* program covering 36 sites in Montserrado and Nimba Counties, 73% of participants received HIV counseling and testing on the clinic celebration day. Over half of the female participants received FP counseling and chose a modern method—far above the contraceptive prevalence rate in Liberia.

In June 2013, PSI and the Education Development Center (EDC) implemented a peer educator training with 30 youth graduates of the *HealthyActions* program. The peer educators received a three-day training and are now equipped with an audio-based curriculum to deliver to their youth clubs and communities. The audio, which can be played on a mobile phone, acts as a co-facilitator for the peer educator, who then implements a group or one-to-one session based on activities found in the original *HealthyActions* curriculum. The peer educators report the number of young people reached through their sessions on the mobile phones and provide referrals for HIV counseling and testing and FP services.

Youth played a crucial role as advisors in the design and delivery of *HealthyActions*. Prior to development, a group of young people came together for an informal focus group discussion on their knowledge of and attitudes toward HIV and AIDS, condom use, HIV counseling and testing, FP, teen pregnancy, and youth-adult communication. They were also asked to share ways they like to learn and recommendations for interactive activities. The same group, with the addition of several other young people, met a second time to test some of the activities, provide feedback, and offer suggestions for improvement. This exercise was critical to the development of the *HealthyActions* curriculum.

In 2014, PSI Liberia will be launching a new social franchise of FP clinics with a focus on youth-friendly services.

Caribbean



Meet Kristina: *Kris is 16-years-old, living in difficult circumstances in Barbados with her grandmother and younger sister. Kris "grew up early," dropped out of school at 15, and began taking risks. Kris wears the latest trendy clothes, has a smart phone, and is well-networked within the community. She enjoys hanging out with friends and, while not currently employed, has had jobs as a sales clerk at a clothing store and at a fast food outlet as a cashier. Kris occasionally receives money from a relative abroad and from older sexual partners. Kris has been known to engage in sexual activity at clubs, on the beach, and in deserted areas. She is aware of the benefits of condom use and can get one with little difficulty. She uses condoms at the beginning of new relationships but soon stops since there is now an assumed level of trust – despite the fact that both Kris and her partner currently have other sexual partners. Pregnancy is not on Kris' agenda at this point, so contraceptives other than condoms are used when she is in more serious relationships. Kris' risk perception for contracting HIV or STIs is low so she does not get screened. Kris has little knowledge of other sexual and reproductive health issues and will not seek treatment until visible signs become evident. Kris also believes that seeking medical care is expensive and is unaware of the various affordable services offered at local clinics.*

PSI/ Caribbean recently launched an initiative to tailor services to three target groups – men who have sex with men, female sex workers, and youth. PSI/Caribbean has been conducting client exit interviews at clinics, incorporating new FP modules in service provision, renovating clinics, and creating a referral guide for BCC to create the program. Since PSI/Caribbean does not yet have a social franchise network, youth-friendly services are offered through IPPF-affiliated and private sector clinics.

Peer Education

PSI/Caribbean involved young people from the community to assist in the design and delivery of a unique peer education program. A cadre of peer educators is recruited from the local community, representing youth from the wider population, not just in-school youth who are viewed as “model students.” This helps to ensure that youth like Kris and her friends can relate to the educator. PSI/Caribbean develops unique BCC field guides to first identify questions and needs from an area or group, and then create fun and engaging activities tailored to these identified needs. For example, peer educators may use games like “Sex Busters” or “Match Maker,” in which participants match a risk to an activity. The sessions cover any topic under the SRH domain. Participants are then referred to local health services, and PSI/Caribbean’s robust referral system enables the country program to track the referrals. The sessions may be held in small groups and sometimes individually. As a result, a slew of very positive responses from the target audience and from the overall community have been received. Each month, peer educators conduct about 30 activities per county, reaching approximately 300 people per month in each county. All PSI/Caribbean peer educators are trained on BCC methodology and are paid on a performance scale based on the number of completed activities, clinic spot checks, and data entry.

Social Media

In 2005, the Caribbean market was flooded with condoms, but actual usage was low. Market survey results showed that in the Caribbean: 1) most communities were small; 2) many people were uncomfortable talking about sex, condoms, and RH; 3) youth did not identify with portrayals of risk groups; and 4) vendors were not comfortable selling condoms.

In response, PSI/Caribbean created a category campaign called Got it? Get it (GIGI) with the aim of growing the total market for condoms by making safer sex practices more available and appealing to youth at risk of acquiring HIV. In a region with HIV prevalence rates second only to Sub-Saharan Africa, this powerful, youth-oriented, “Caribbean-flavored” brand is changing the way people think and talk about sex. Since 2005, through the social marketing of GIGI, PSI has 1) sensitized over 1,500 retailers on HIV and AIDS, condoms, and non-discrimination against purchasers; 2) aired 2,356 TV spots over a six-month period and 2,126 radio spots over a two-month period; and 3) conducted over 4,000 interpersonal communication (IPC) activities that reached over 50,000 people (new and repeat).

In 2009, PSI/Caribbean conducted another market study that highlighted: 1) internet connections and BlackBerry use were high, 2) at-risk youth were spending significant time online, particularly on Facebook; 3) online information can be sought anonymously, pushed out to users where they are, and is often deemed more reliable; and 4) one post can reach many. Armed with this understanding of youth online and sexual behavior, plus GIGI’s existing popularity, PSI/Caribbean launched a dynamic social media strategy to grow the total market for condoms and reduce stigma around sex among the Caribbean’s most at risk youth. Today, the program boasts the fifth most popular Facebook page in the Caribbean, with over 33,000 “likes.” The Facebook page, which reaches 12-14 different islands, offers games and activities, as well as assigned health educators who interact with subscribers. Regular posts range from greetings to aspirational messaging to factual messages focused on safer sex. Field IPC teams submit monthly reports describing their activities, who they reached, and questions they receive, which are transformed into Facebook content and future activity plans. By tagging other organizations, GIGI is able to gain fans, build partnerships, and foster collaboration.

On its website, PSI/Caribbean has an avatar named Gigi to field anonymous questions from fans. The site also posts questions received from the field anonymously for Gigi to answer. Gigi has a Facebook profile and interacts with the page by posting on it, thereby increasing interaction. Additionally, PSI/Caribbean transformed two offline IPC activities into online games linked to its Facebook page, where fans can compete with friends and share their scores. The Facebook page also is used to host online focus groups for pretesting of television ads, combined with offline surveys, to strengthen the diversity and number of responses that inform the ad campaign.

Madagascar

Lalatianna is graduating from high school next year and would like to continue her studies to become a nurse, but her family is not able to afford it. At 17-years-old, Lalatianna has high hopes that she will have a job, get married, and wait until her mid-twenties to have children. When she is not with her boyfriend, she likes to spend time with her younger siblings and read stories to them. She and her boyfriend of three months are trying to use condoms regularly, but they often run out or don’t feel like using them because they trust each other. Lalatianna would like to get

tested for STIs and HIV as well as start using the pill, but she is at school all day and commutes 40 minutes each way. Thus, she can never find the time to go to a health care provider to get tested and get the pill. The nearest clinic is 20 minutes away from school but is in the opposite direction from her house.

TOP RÉSEAU

- In 2012, 58,213 girls and 20,268 boys (15-24) were seen through Top Réseau for sexual and RH services, and 40,000 of them came for FP-specific services.
- Since 2000, over 800,000 youth have been served by Top Réseau, 45% of whom were 15-19 years old.

PSI/Madagascar started its social franchise network, Top Réseau, in 2000. The primary goal of the network is to provide RH services to youth. Today, the 248 clinics are not just for youth – anyone can use their services – but are still geared toward offering a welcoming environment for youth, where clinic personnel and providers are trained to offer youth-friendly services. In fact,

a 2013 survey among the general population found that over 90% of respondents said that Top Réseau is a “youth clinic.”

Examples of the network’s services include FP, STI screening, HIV counseling and testing, and cervical cancer screening. In order to remain a member of the network, clinics must meet certain criteria, such as having convenient hours of operation, ensuring confidentiality, creating a welcoming and comfortable environment for youth, and receiving trainings to serve youth health needs.

Through its formative research, PSI/Madagascar developed a multilevel communication campaign that promotes the Top Réseau network and behavior change through peer education, mobile video units and mass media. Each Top Réseau site assigns youth peers to certain zones where they perform outreach activities to refer clients to the clinics. The peer educators distribute flyers outlining the services, attributes, locations, and hours of the network clinics. In addition, a musical group, “Tearano,” popular with youth, produced a song, music video, and jingle for Top Réseau that was played on radio and TV. The jingle was used to frame educational radio and TV spots sponsored by Top Réseau.

Guatemala



Meet Esther: Esther studies in the morning at the public school, and in the evenings she takes care of her little brother in Apopa. She is 16-years-old and likes to dress nicely and look “cool” and attractive. She has had a boyfriend for five months, and recently started having sex after pressure from her boyfriend who becomes threatening if she doesn’t prove to him that she loves him. Esther is afraid that her parents and neighbors will find out that she is already sexually active. She does not have adequate knowledge of FP methods or HIV and STIs, but she is ashamed to ask about those topics. Her school briefly covered STIs and HIV but the information was not very clear to her. She would like to wait to have her first child after she finishes school.

One out of five Guatemalan mothers is between the ages of 10 and 19, constituting the highest adolescent fertility rate in Latin America. In 2012, 22% of births occurred among girls in this age group. In the Western Highlands nearly 19% of all girls drop out of school before the age of 10 (Sebastian & de Anda, 2013). Thus, the need to support the development of skills in life planning education, including SRH, is especially critical for girls in this region. PSI and its local affiliate, PASMO

Guatemala, is targeting girls in the Western Highlands to increase their knowledge, attitudes, and practices about SRH and is promoting delayed sexual debut to reduce unintended pregnancies and school drop-out due to unintended pregnancies.

In Guatemala, PSI/PASMO developed and implemented a series of community-based educational activities to increase protective behaviors to prevent unintended adolescent pregnancy. An integrated BCC intervention focused on preventing adolescent pregnancy through life planning called “The Train Will Wait Until You’re Ready,” involved more than 750 youth. This theme was then used to counteract the local slang “the train will leave you,” which is often used in a context to pressure girls to enter into romantic relationships and engage in early sexual debut. As part of the intervention, a series of public events were organized to engage youth in discussions on various themes including abstinence and delayed sexual debut, fertility awareness, FP, HIV and STI prevention, correct condom use, adolescent pregnancy prevention, and how to develop a life plan. To complement the theme, a small scale reproduction of a passenger train was created and each participant was given the opportunity to have their picture taken in the engine compartment posing as the conductor of their own “life train.” The photo was later incorporated into an exercise where each participant described her own life plan in writing. The design of a train with miniature train cars was used to represent goals for distinct stages of their own lives, including their plans for education, friendship, travel, work, and future family. Upon completing their plan, each participant was presented with their written plan as a concrete and personal reminder.

Evaluation of the intervention showed that of 81 participants who completed the life planning exercise, 98% indicated that their current most important priority was the pursuit of their education and 95% were presently not ready to have children. When asked what key messages from the intervention they considered to be most important, 17% reported “complications resulting from adolescent pregnancy”; 16% remarked on the importance of “abstinence and delaying sexual relations”; followed by 15% reporting “how to plan and control your own life”; and 13% said “HIV and STI transmission.” Furthermore, survey results indicated that the interactivity and creativity of the intervention generated very positive responses from the group – 99% of the participants enjoyed the train activity.

El Salvador

Endemic levels of sexual violence and gender-based violence have made El Salvador one of the most dangerous countries in the world for girls and women. One in four women between the ages of 15 and 49 reported ever having experienced physical violence by a partner. A study in 2012 on violence experienced during the past 12 months found that 9.3% of adolescent girls in El Salvador aged 15-19 reported physical or sexual violence by a partner, compared to 9.1% among 20-24 year olds, 8.6% in 25-29 year olds, and 7.8% in 30-39 year olds (PAHO 2013).

PSI/PASMO’s youth program in El Salvador includes comprehensive topics that support youth, ages 12-24, to build life skills surrounding condom negotiation, SRH, STI prevention, and gender-based violence prevention. Recognizing that gender-based violence is a public health problem and one determinant of high-risk sexual behavior, PSI/PASMO emphasizes the prevention of gender-based violence and sexual violence in all of its interventions:

- School- and community-based training programs and workshops for youth to raise awareness of GBV and promote healthy relationships and mutual respect among young people.
- Training program for teachers and counselors on methodologies for addressing rights, SRH and violence prevention through educational curricula; in 2012, PSI/PASMO trained more than 450 teachers on adolescent health and preventing school violence.
- Training program aimed at parents and caregivers, schools, and communities where PASMO intervenes; in 2012, PSI/PASMO trained 250 parents of at-risk young people in communication, sexuality, and violence prevention.
- PSI/PASMO is also active in strengthening local public policies related to violence prevention and youth.
- In partnership with local sports organizations and NGOs, PSI/PASMO implemented 21 activities addressing violence and sexual exploitation prevention, reaching over 500 youth from local schools and communities.

LESSONS LEARNED: CHALLENGES AND OPPORTUNITIES

Below is a summary of the key challenges and barriers that PSI has faced in delivering health programs to young people, with promising opportunities for overcoming those barriers based on PSI's experiences and successes.

Barrier: National laws dictating the legal age (i.e., the age at which an individual is entitled to certain rights and decisions) vary by country. Thus, program implementers may find that existing laws prohibit certain activities from targeting youth under the legal age. This is especially true for activities and interventions that touch on SRH topics, since talking about sex and sexuality is often considered taboo. As the target audience of SRH interventions expands to include younger girls, implementers are finding that national laws are particularly difficult barriers to overcome. For example, PSI/Madagascar was recently forbidden to broadcast mass media spots on FP targeting young people. The country's Ministry of Health does not allow organizations to communicate messages on sexuality to youth, particularly to young girls. In the Caribbean, while the culture may be hyper-sexualized, the prevailing religious values make discussing sex and sexuality taboo. Elsewhere, some laws prohibit a young girl from obtaining contraceptives without the consent of a legal guardian until she is of legal age, which may vary by country, at which point she is likely to already have at least one child.

Opportunity: PSI/Madagascar discovered that while it is forbidden to advertise a specific FP service or clinic, it is permissible, with some restrictions, to advertise a network through these channels, as well as through IPC and printed materials such as flyers and posters. A health provider network or product is also allowed to sponsor an educational message broadcast on mass media. Therefore, billboards promoting the brand Top Réseau, with no indication of services, were approved by the Ministry of Health and set up in certain regions. In the Caribbean, PSI seizes festive and celebratory opportunities, such as carnivals and community events, to integrate messaging about SRH for youth.

Barrier: Each country and region may define youth differently regardless of the legal age. In one area, a 15 year-old-girl who is considered ready to marry and bear children may not have the same needs and preoccupations as 15 year-old school-going girl who has not yet reached puberty. In other scenarios, girls ages

16 and younger have difficulty accessing FP because culturally they are not expected to use it if they have not yet given birth. These norms for what behavior is expected by youth reinforce cultural ideals and stigma among providers, policy makers, parents, and other key community members. Similarly, cultural norms surrounding gender can dictate who is able to make SRH decisions. These norms, which usually place men in positions of control and power, are at the root of harmful traditional practices and gender-based violence. Furthermore, gender inequality fosters barriers to accessing SRH services, information about FP, and contraceptive method of choice, among many other things.

Opportunity: Community attitudes, including those of parents, faith leaders, teachers, providers, and others, play a critical role in how impactful youth programs can be. If these "influencers'" beliefs or attitudes contradict program messages, young people can be left confused and misguided. Thus, working with parents, families, and community leaders is imperative to ensuring that messages are streamlined and consistent, and that those "influencers" act as team players in ensuring young people have access to the information and services they need. Community-level interventions that include gender awareness and gender transformational programming have proved to be successful. These programs work with young people and their influencers, often separately, to explore and change negative social norms that drive gender inequality.

Barrier: The importance of involving young people in program design, delivery, and evaluation cannot be stressed enough. However, there are inherent barriers and challenges to meaningful youth engagement. Often, the young people that are engaged do not necessarily represent the young people that programs are ultimately trying to reach. For instance, it is common for youth peer educators and staff members to be well educated, urban, and living with some level of wealth and access to services and resources. While all young people should be given opportunities for leadership, it becomes problematic if these are the only youth who can influence programs, travel to conferences, join coalitions, and have access to key decision-makers.

Opportunity: Greater efforts need to be made to engage youth from diverse backgrounds – out-of-school youth, married youth, young girls with children, HIV positive youth, homeless youth, young people from key populations, etc. Partnering with local and regional organizations that have direct access to these young people is one way to get closer to them and be able to hear their needs.

Barrier: The lack of age-disaggregated data remains a major barrier for successfully advocating for, implementing, and evaluating youth programs. Countries have different definitions for “youth,” and many programs limit their own data collection to just two or three categories (e.g., under 15 and over 15), making it difficult to draw insights on what young people need and how to improve services and programs.

Opportunity: Programs are encouraged to disaggregate their data by sex and by age into categories such as 10-14, 15-19, and 20-24 years old. This allows researchers and programmers to investigate the needs of young people throughout their development life-cycle, and tailor programs to specifically meet those needs.

Barrier: Many organizations and programs work in silos. While there is increased access to knowledge management platforms designed to compile evidence-based tools and resources, these platforms are sometimes poorly managed and outdated, or not accessible by teams in the field. Equally challenging, is that organizations continue to operate in “mono-sectors,” rather than finding better ways to integrate health with other areas of youth development such as education and livelihoods.

Opportunity: It is important to continue investigating ways to share resources, tools, and best practices within and among organizations. This means creating venues, both in-person and virtual, for organizations to talk about their programs, challenges, successes, and questions that remain to be answered. The expansion of mobile technology and social media can help organizations think creatively about how to share their experiences, as well as engage young people in those discussions. Programs may also consider the importance of a multi-sectoral approach. While we work to build the quality of SRH services and messaging in the health sector, we need to concentrate on ways to integrate SRH into other sectors such as education and work.

CONCLUSION

Over the years, PSI has learned valuable lessons from its work with young people, particularly about identifying opportunities to reach young people and challenges that must be overcome. Legal, cultural, situational, and other structural factors present significant barriers, despite our capacity, resources, and expertise. However, the good news is that barriers that previously hindered youth programs from making significant health impact are slowly dissolving. Governments, both global and domestic, are beginning to make a concerted effort to identify the unique health needs of young people and to stress the importance of meaningful youth engagement in program design, delivery, and evaluation. We must continue to build on this growing global momentum to put young people at the center of our programs and to find ongoing and creative ways to listen to them, bring them to the table, and work alongside them to create programs that will help them build healthy and successful futures.

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