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**FOCUS on Young Adults  
Partner Dialogues 2001**

*A Dialogue on  
Social Marketing and Other Commercial Approaches  
to Improving Adolescent Reproductive Health*

Thursday, February 15, 2001  
Washington, DC

**Meeting Report**

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## Acronyms

CDC	Centers for Disease Control and Prevention
CMS	Commercial Market Strategies Project
DHS	Demographic and Health Surveys
FOCUS	FOCUS on Young Adults Program
PSI	Population Services International
SEATS	Family Planning Service Expansion and Technical Support Project
USAID	U. S. Agency for International Development

## **I. INTRODUCTION AND BACKGROUND**

On February 15, 2001, the FOCUS on Young Adults program hosted a half-day meeting in Washington to discuss social marketing and other commercial approaches to improving adolescent reproductive health. A total of 24 participants attended the meeting, including 3 from FOCUS, 2 from USAID, and 19 from partner organizations.

The objectives of the meeting were to:

1. Increase understanding and awareness of the latest efforts to involve the private commercial sector in meeting adolescent reproductive health needs.
2. Examine the accomplishments of the various commercial sector approaches as they relate to adolescent reproductive health.
3. Discuss the possibilities for applying these commercial approaches to adolescent reproductive health on a broad scale.

In advance of the meeting, participants received and were asked to provide feedback on a draft report by Judith Senderowitz and Christine Stevens titled "Leveraging the For-Profit Sector in Support of Adolescent and Young Adult Reproductive Health Programming." A final version of the paper is currently being prepared and will be sent to dialogue participants shortly.

## **II. MEETING HIGHLIGHTS**

### **A. Introductory remarks**

Lindsay Stewart, Deputy Director of the FOCUS program, welcomed the dialogue participants and noted the importance of the commercial sector as a medium for providing both information and services to young people. Almost four years ago, FOCUS commissioned a paper on social marketing and held consensus panel discussions on the topic. Much has happened in the intervening years, and FOCUS feels it is useful at this time to bring together a group to talk about the commercial sector and youth.

### **B. The potential of the commercial sector to meet adolescent reproductive health needs**

*Use of the private sector by adolescents.* Nancy Murray, FOCUS Policy Advisor, first presented evidence on where adolescents go for reproductive health services (see Annex 4 for overheads from her presentation). Preliminary findings on adolescent use of private sector family planning services are based on a secondary analysis of nine recent Demographic and Health Surveys (DHS) and four other recent surveys carried out with assistance from the Centers for Disease Control and Prevention (CDC). Adolescents' use of the private sector, including both the commercial sector and nonprofit groups, is high—above 50 percent of the family planning market in half the countries, and above 30

percent in the rest.<sup>1</sup> Thus, a large potential role for the private sector already exists, one that needs to be aggressively explored.

Preliminary analysis shows that, in a number (but not all) of the countries analyzed, adolescents are more likely than other age-groups to use the private sector as a source of family planning. Murray plans more detailed analyses by method of family planning and comparing age-groups and single versus married youth. One challenge with this type of analysis is the small sample size; finding significant differences between groups is difficult. Moreover, the DHS does not give data for the under-15 age-group.

We often assume that young men use the commercial sector more than young women, but the evidence to support such an assertion is still scant. Some qualitative studies do suggest that young men are more comfortable than young women going to private sector outlets such as pharmacies to purchase condoms. Many methodological problems make it difficult to use the survey data to compare the patterns of use by young men versus young women's use. For example, CDC surveys include information on young men, but the DHS generally does not.

*What youth are willing to pay.* In the second part of the presentation, Murray presented evidence on whether adolescents are different from other age-groups in terms of their willingness to pay for reproductive health care. Three recent studies look at willingness to pay increased user fees for a variety of reproductive health services: in Ecuador (for obstetrics and gynecology services); in Egypt (for family planning services); and in Mali (for family planning products). Researchers asked *current* clients if they would be willing to pay a substantial fee increase over and above the prevailing price. The studies did not examine the willingness to pay of youth not currently using a service. The main—and rather unexpected—finding is that younger people are not significantly less likely to be willing to pay fee increases. In other words, a client's age is not a significant predictor of willingness to pay. In fact, in Ecuador, 20- to 24-year-olds are *more* likely to pay a fee increase. As expected, however, the higher a client's income, the greater their willingness to pay higher prices for services.

Another key finding—with important implications for serving adolescents—is that single, sexually active women are more willing to pay fee increases than married women. One explanation is that single, sexually active women (the bulk of the adolescent age-group in most countries) are more motivated to use services and thus more willing to pay for them.

Murray finished with four recommendations to help expand our knowledge of willingness to pay among adolescents:

1. We must begin to look at the large segment of the adolescent group that is not using modern commercial sector services and how cost influences them. Thus far, we have only examined the data for youth who are already clients.
2. We need to look much closer at young men, their use of services and the influence of cost on their use.

3. We need to think hard about how to measure income for young adults. The definition could vary by age and marital status.
4. We need larger sample sizes for the under-20 age-group to be more comfortable with the validity our findings.

The subsequent discussion produced the following recommendations for further research and for helping to make better use of existing data to encourage greater commercial sector involvement in adolescent reproductive health care:

*Distinguish between youth use of modern and traditional private providers.* Surveys and other studies need to look more closely at informal, traditional providers and their clients. Young people who do not patronize formal facilities may patronize informal facilities and services. Those who do patronize the formal facilities through social marketing or other channels may also patronize the informal sector depending on what reproductive health information or service they are seeking. Clients of informal services may be given credit, charge less than formal sector providers, and be allowed to pay in kind. Informal providers may be more approachable for youth, for cost and other reasons.

*Look beyond the DHS and CDC surveys.* Qualitative data from a number of smaller studies indicate that youth have a strong preference for private sector facilities. One important reason unmarried young people shun government-run services is the judgmental attitude of many health workers in the public sector and the lack of privacy and confidentiality. Exciting new sources of information are the youth surveys carried out with the assistance of the East-West Center in some Asian countries. The surveys sample *single* youth—something that the DHS generally does not. However, only the more recent of the East-West Center surveys ask youth where they obtain their family planning methods. Population Services International and other groups doing social marketing often collect information on youth purchasing behavior. Typically, however, such information is part of a broader consumer survey, and further analyses are needed to distinguish the buying patterns of young people from those of the general population.

*Explore further the question of whether adolescents control their own income.* We must look beyond household assets alone and examine the amount of discretionary money that adolescents control. Although youth may earn income, a substantial portion may go to their parents or others. A recent survey carried out with the assistance of the Commercial Market Strategies project in Jamaica asks adolescents about control over their income; preliminary results from the survey should be available by the middle of this year.

*Disaggregate willingness to pay data.* Willingness to pay depends on whom you ask. Men may answer differently from women, depending on restrictions on disposable income. For example, when Profamilia/Colombia opened its clinics for men, they found men willing and able to pay more for the service than women. One reason may have been that, while women were in charge of the family budget, men had more disposable income. For adolescents, something similar may be at work. Married youth may have more restrictions on their disposable income.

*Do more thorough price analysis.* Asking an adolescent to pay something to help a nongovernmental organization recover costs is one thing; it is entirely different to ask the same young person to pay full commercial price. It is also important to know the relative weight of price versus other factors such as ease and comfort in the decision by an adolescent to use services. We know from surveys that very few people cite cost as a reason for not using contraception. This holds for youth as well. On a recent survey in Mali (carried out with assistance from Abt Associates and FOCUS), only 1 percent of youth said price was a barrier to their use of various health services. Yet 40 percent of youth said they simply did not have the money to pay. Thus, it is important to recognize that just because willingness to pay studies show no difference among age-groups, that does not mean that adolescents face no economic barriers to use of services.

*Show manufacturers and distributors the potential of the youth market.* Companies know that young people are an important piece of the market, but do not always know how to tap into the youth market. They typically look at past sales to project future sales. They generally do not know the potential for growth among nonusers of condoms and other reproductive health products. They are not familiar with DHS-type surveys—which are far too expensive for a single company to undertake—but appreciate the detailed data that such surveys generate. Using such data, we can help them think about the future of their market—its size, whether and how much youth are willing to pay. This is one important way to get the commercial sector more interested and involved. It is a unique source of useful data that we have to offer to the commercial sector.

*Expand the scope of price studies.* The commercial sector is very interested in price information. We should ensure that more large-scale DHS-type surveys include price information (only a few do now). We also need to expand the sample size of price-sensitivity studies to ensure we can do appropriate analysis for the adolescent age-group.

*Don't underestimate cultural barriers to commercial sector interest.* Companies may be unwilling to risk marketing controversial products to unmarried women. Note, for example, the frustration in marketing mifepristone and emergency contraception in the United States. Recognizing and addressing such cultural barriers is important.

*Look more closely at how we can promote brand loyalty.* Business likes the idea of attracting consumers at a young age and building lifelong brand loyalty. In the United States, for example, Lifestyles gives out millions of condoms free to school kids, in the hopes they will continue to use their product as adults. However, the public health community has not nurtured the concept of brand loyalty. Social marketing programs frequently switch brands, as do most public sector programs. By thinking more about how we can encourage brand loyalty, the commercial sector may be more interested in working with us.

*Apply country-specific strategies.* The modern commercial sector has little interest in many poor countries or regions, for example, most of Africa and rural areas everywhere in the developing world. Different strategies are needed for different countries and regions within countries.

**C. The range of commercial approaches to meeting adolescent reproductive health needs**

The second session of the dialogue was a two-part panel presentation.

**PART I** -- The first panel looked at strategies to provide information and services through the commercial sector.

***Presentation #1: Social Marketing for HIV/AIDS Prevention in Indonesia.*** Reed Ramlow, Senior Associate, The Futures Group International. (See Annex 4 for the overheads from the presentation.)

The Futures Group partnered with condom manufacturers to increase condom use among sex workers and their clients in red-light districts in Indonesia. Although the intervention did not specifically target youth, nearly half of sex workers are between 15 and 24 years old. Their clients—mainly government workers and businessmen—tend to be older.

The program consortium included one international and two local condom manufacturers. Condom companies know that the sex trade and young people are important consumers of their product. The commercial sector was interested in a targeted effort to reach the sex trade and in expanding distribution to young people. The local condom manufacturing industry has plenty of capacity and was hoping to expand sales. The commercial manufacturers saw the project as an opportunity to obtain marketing support as a means to increase sales. One of the local companies had been participating in a social marketing project for several years. The second local company had been a government supplier and wanted to develop its commercial marketing effort. The multinational member of the consortium, London International Group, already was targeting the youth market and advertised heavily on MTV.

The program strategy was to heavily promote condoms in red-light districts while making condoms easily available both on the street and inside bars and brothels. Nonprofit groups collaborated with the commercial sector on a number of educational events, including at bars and universities. The program hired a public relations firm to place newspaper articles related to the campaign and to HIV/AIDS prevention.

The project dramatically increased condom availability and visibility. A survey found that the percentage of sex workers using a condom during their last sexual encounter rose from 36 percent to 48 percent during 1999. More than one-third of the clients in the red-light areas said they used condoms because they felt personally at risk. Research did not attempt to measure the program's impact on the prevalence of sexually transmitted disease. The condom manufacturers spent roughly four times the amount of money invested by The Futures Group (\$300,000) and decided to sustain the program after the funding ended. One of the manufacturers planned to launch a premium brand at a higher price.

Issues raised during the subsequent dialogue:

*Negotiation of condom use.* The program operated at various levels to address the relative lack of power of young female sex workers in negotiating condom use. Nongovernmental organizations worked to educate sex workers on this issue, usually with the cooperation of brothel owners. At the same time, mass media and other communication efforts promoted the normalization of condom use—thus relieving young girls of the sole burden of having to “sell” their clients on using a condom.

***Presentation #2: Working through Nurses and Nurse-midwives in Zambia.*** Tim Williams, John Snow, Inc. (See Annex 4 for the handout that accompanied the presentation.)

The Family Planning Service Expansion and Technical Support Project (SEATS) worked with the Zambian Nurses Association to create a more youth-friendly environment in the places where nurses and nurse-midwives work, increase the comfort level of young people attending such services, and boost youth utilization of clinical care. In many countries, nurses and nurse-midwives provide the bulk of reproductive health care. On the other hand, they are also perceived as being part of the “problem,” i. e., often scolding or highly critical of youth seeking family planning and other reproductive health care.

Of the 500 nurses and nurse-midwives who received the youth-friendly services training through the nursing association, an unknown number developed quality improvement plans that emphasized a youth-friendly strategy. As a complement to the training of nurse-midwives, the program trained peer educators and promoted the clinic services at schools and other places where youth meet. A simple, qualitative evaluation using interviews and focus group discussions followed up 27 nurses at 14 sites to assess their experience in implementing youth-friendly services. All nurses could name at least one characteristic of a youth-friendly service and three-fourths could name at least five characteristics. Eleven of the 14 sites had implemented youth-friendly services to a greater or lesser degree. Client exit interviews found some improvements in care.

During the project, private midwifery was still illegal in Zambia. A similar situation had prevailed in neighboring Zimbabwe until the government legalized private midwifery practice. Hundred of midwives there who were operating semi-legally now openly provide care and have organized themselves into a vibrant professional organization. A comparable process is expected to occur in Zambia, once the government lifts restrictions on private practice. Because of the restrictions still in place, SEATS worked exclusively with public sector midwives. Some relevant lessons can, nonetheless, be applied to private practice midwives:

- Private sector midwives must balance social objectives with financial needs, and that has important ramifications for young people who may not have the resources to pay.

- Time and resource constraints—a huge factor in limiting the quality of public sector services—are presumably less in the private sector and might result in better quality of care.
- Although private midwives may have trouble in the short term profiting from youth (who are unlikely to be able to pay full price), midwives can use youth services as a way to pull in other kinds of clients, and to build a clientele who will soon be full-paying adults.

To summarize, midwives can fill a niche between the public sector and the private physician. They may be able to offer contraceptives at more affordable prices than private doctors, and to cover the costs so that eventually they bring in enough clients to make youth-friendly services a profitable addition to their array of services.

Issues raised during the subsequent dialogue:

*Public and private roles are blurred.* In sub-Saharan Africa and elsewhere, many public providers also maintain private practices. It is also difficult to generalize about the motivations of those in the public or private sector. It may well be that the more socially committed midwives are also those who are willing to establish services for young people. Still, those in private practice must balance social objectives with staying in business.

*We know little about private providers, but the experience is growing.* To date, we have very little documentation of programs that encourage private providers to provide adolescent reproductive health care. Some recent efforts include: (1) a new project in Madagascar where Population Services International (PSI), under the Commercial Market Strategies (CMS) project, is helping to establish a network of 11 private clinics specifically working with youth; (2) a project in Kenya that gives vouchers to young people for use at either private or public sector providers; and (3) a PRIME-assisted project in Ghana, where private practice midwives are encouraged to make their services youth-friendly.

**PART II**--The second half of the panel examined strategies for tapping into the commercial sector for funding and expertise to address adolescent reproductive health concerns.

***Presentation # 3: Working with Business: The Global Alliance for Workers and Communities.*** Kevin Quigley, Global Alliance for Workers and Communities. (See Annex 4 for the handouts from this presentation. More information on the Alliance is available on line at [www.theglobalalliance.org](http://www.theglobalalliance.org).)

Millions of young people go to work every day. The Alliance tries to change the workplace—in its view, a new venue for human development. The Global Alliance is an approach, not a project. It is a fourth-generation corporate social responsibility activity, a strategic partnership with the World Bank and a select group of global brands, including Nike and Gap. So far the Alliance works in Indonesia, Thailand, Vietnam, and China. It

is launching a program in India within the year. Although starting in Asia, other regions will also be involved.

The demographics of light manufacturing are such that, in the factories where the Alliance operates, about 80 percent of workers are young females. The Alliance uses a participatory assessment approach that involves surveys, focus groups and in-depth interviews in a factory setting. The Alliance has sponsored 9,000 one-on-one interviews done by local researchers. Health, especially reproductive health, emerges as a top priority. After the assessment stage, the Alliance turns for program expertise to local, regional and international partners. In Thailand, for example, the Alliance began training programs in five Nike-affiliated factories in collaboration with the Thai Family Planning Association and the Thai Red Cross.

Funding for the Global Alliance comes out of the companies' business budgets—not out of marketing or community affairs. Why? Because the companies believe this approach will produce benefits for the workers and their partner companies. Tapping into the business budget is key, because the amount of money available for philanthropic activities is usually very limited.

Global companies don't own their own factories. They are supplied from thousands of factories around the world. The keys to sustainability are the factory managers, who must be persuaded that it is in their economic interest to invest in the health of their workers. The managers have been exceptional allies so far. The Alliance is trying to give voice to workers as well as to factory managers.

Issues raised in the subsequent dialogue:

*Motivating factory managers to participate.* To convince the factories to participate, first you need a foot in the door. Nike and the other major brands provide that leverage. Managers are skeptical of the approach at first, so you need concrete, measurable indicators. Health is great in that respect, because better health means less sick leave, reduction in replacement costs, lower turnover: these directly affect factory bottom line. The most effective action is to persuade the factory managers to convince each other that improving the workplace is good for business.

*The progression from the Alliance input to the factory assuming responsibility.* Progression must be gradual. The Alliance has a 10-year commitment from its major corporate sponsors, so that allows some time. It must be clear that the Alliance will get involved only if factory managers think it will help them. Eventually, there must be ways for factories to sustain the investment. But it is also good to remember that access to workers and their time—inputs that only factory managers can provide—are often the most important resources.

*Evaluation.* The Alliance is in the process of designing an evaluation. It hopes to measure impact for workers, factory managers, and Nike, Gap and other global brands. By

identifying and working with leading brands, the Alliance hopes that competitors emulate their actions.

*Sexual harassment and coercion in the workplace.* These problems definitely exist. Cultural differences contribute to the harassment. One of the key approaches of the Alliance is to work with management to change attitudes.

*Setting up local partnerships.* The Global Alliance is housed at the International Youth Foundation in Baltimore. It has a network of partner organizations in 60 countries. For example, the Thai partner is a consortium of 35 nongovernmental organizations. The Alliance carries out an assessment, putting together a project team in each factory that includes a union and management representatives and workers from different factory departments. The team helps design instruments and interpret results. The Thai project team looked at which organizations could provide reproductive health services. Through a transparent, competitive process, the Alliance then contracts for such services.

*Connecting the Alliance with groups working on adolescent reproductive health.* The International Youth Foundation does not have reproductive health expertise, and thus hopes to find ways to tap into the reproductive health community—at the local, regional, and international levels. The Alliance is very open to suggestions from participants in the dialogue regarding reproductive health service providers, particularly those who are based in the countries where the Alliance operates.

*Moving beyond the workplace.* The workplace is a great entry point into the community. Given its limited resources, the Alliance for now focuses on the factory but hopes to eventually strengthen the nexus between the factory and community. In addition, a key part of the strategy is to engage the public sector beyond just dialogue.

***Presentation # 4: Partnering with the U. S. Television Industry: The Media Project.*** Debra Hauser, Advocates for Youth. (See Annex 4 for the handout from this presentation. More information on the Media Project is available on line at [www.themediaproject.com](http://www.themediaproject.com).)

Begun 20 years ago, Advocates for Youth's Media Project is now underwritten by the Kaiser Family Foundation, with an annual budget of about \$400,000. The project's objective is to educate, empower and encourage the U. S. -based TV industry to incorporate positive images about adolescent sexual and reproductive into their programs. TV is enormously powerful: U. S. kids watch 3 hours a day on average, 20,000 hours before they reach adulthood. Young people in the United States say that TV is one of their primary sources of information on sexuality and family planning. Many shows produced in the United States are seen by millions more worldwide.

Relationships—which take a long time to build—are absolutely key to industry involvement in the Media Project. The project staff are of and from the entertainment community. They nurture those relationships very delicately. Many in the U. S.

television industry are motivated to participate because they do care. Also, they are constantly criticized for putting sex on television and fear that if they put out information, they will be accused of promoting promiscuity. The project says to them: you can use TV in a way that benefits everyone.

The project works in three ways. The first is to influence the story lines of shows that reach mass audiences of youth (typically 3 to 5 million people in the United States), often with the aim of normalizing positive behaviors such as condom use. The second is to produce public service announcements. The UPN network, for example, is airing announcements in prime time that tie into a website and into an emergency contraception hotline. Kaiser paid to produce the announcements, and the actors and directors worked for free. UPN airs the messages at no cost. The third piece is political. The project holds informational briefing on political topics. Sometimes the project is able to influence the story line of a show seen by all ages. For example, the project worked with one show to develop a story line with the message that sex education does not promote promiscuity. Some 14.5 million people saw the show in the United States. The annual SHINE awards (Sexual Health in Entertainment) reinforce individual efforts through an awards ceremony that the industry takes very seriously.

Project staff in Los Angeles talk to writers and producers and provide fact sheets, information and script review. Staff also give one-on-one briefings as well as group informational briefing three times a year. The group briefings let industry meet and talk with young people—something they don't normally do.

Issues raised in the subsequent dialogue:

*Competition with other issue lobbies.* The project does not try to compete with all the other "issue" lobbies trying to influence Hollywood (e.g., drugs, tobacco, guns). The work is very low-profile and is based on years of building relationships with key players in the industry. Moreover, sex sells, and thus adolescent reproductive health has an inherent appeal to the U. S. television industry.

*The power of television as a vehicle for information.* An evaluation found that 36 million U. S. viewers saw the "ER" show on emergency contraception. The show increased knowledge about emergency contraception by 17 percent. About 5 million people learned about the subject for the first time through that particular show. After "Felicity" ran an episode on date rape, the rape hotline number immediately received 1,000 calls. It is harder, nonetheless, to prove that kids shift their behavior based on the information they receive on television.

*The potential to adapt the project to developing countries.* Advocates for Youth has contracted to create a plan to reach out to Spanish-language media in the United States and in Latin America. She will be advising on what techniques can be used to affect story lines. Some of the same techniques employed by the Media Project may work with the Spanish-language television industry, but it is still too early to know. In Mexico, many feminist groups and others are trying to reach the media with "issue" messages.

***Presentation # 5: Collaborating with Peruvian Television Networks – Andrea Project.***  
Patricia Poppe, Johns Hopkins University, Center for Communication Programs. (See Annex 4 for the handout from this presentation.)

“Andrea: Time for Love” was a five-episode miniseries aired on Peruvian television in 1998. Produced with financial and technical help from the Center for Communication Programs, the show followed two teen couples. The story line hoped to change gender norms; improve the self-esteem of girls; portray delaying sex as legitimate; portray condom use as the “smart” thing to do; and promote teen-parent dialogue.

A key issue in forging a partnership with the media is understanding the media environment and how it works. This will vary from place to place. Los Angeles is different from New York. Similarly, each country has a unique media environment. For a partnership to take hold, a number of elements must exist:

- There must be local programming. In Peru, local programming comprises 50 to 60 percent of what viewers see.
- Understand what’s happening in prime time. In Latin America, telenovelas and miniseries dominate prime time.
- Identify the main networks and actors, and who makes the final decisions. In Peru, the television industry was booming. The first network the project negotiated with rejected an offer of collaboration. A second, less-established network, searching to capture more of the youth market share, was very enthusiastic about co-production.

Important lessons learned:

- Approach the industry in language they understand, i.e., money, not in the language of social responsibility. Co-production saves the network money. In this case, the project financed half the total budget of \$100,000.
- The comparative advantage of programming with a reproductive health message is that sex sells. And networks recognize youth as an important market for their advertisers.
- Develop a win-win strategy. In this case, the network got the commercial rights to distribute the series in Peru. Johns Hopkins University, and others got the commercial rights for international distribution.

A survey in high schools in the Peruvian capital, Lima, found that 72 percent of girls and 56 percent of boys watched the show. Two-thirds of both males and females thought the story could happen to them. Half of females but only one out of five males had talked to others about the topics portrayed on the show. At the end of each episode a list of hotline numbers and reproductive health services appeared, including those of the Ministry of Health and private sector clinics. Data also exist measuring the effect of the show on use of services.

Issues raised in the subsequent dialogue:

*Scaling-up opportunities.* Financial support is important, but even a little seed money can go a long way.

*Male and female audiences.* The differences in impact on knowledge points out the need for very different strategies for reaching boys and girls through such mass media vehicles.

#### **D. Action recommendations**

In the dialogue's final session, participants brainstormed a series of action recommendations, including the following:

*Help the commercial sector where we have a comparative advantage.* The commercial sector needs to know more about youth sexual behavior, how big the market is, and what the commercial potential is. Local manufacturers in particular are less savvy about identifying and developing a youth market for reproductive health products. International technical assistance agencies can help provide the commercial sector with this sort of valuable information.

*Do more research on the patterns of adolescent use of services.* We need to understand better who private providers are and which youth are using the private sector. Needed actions include:

- Better mining of existing sources of information, including the Demographic and Health Surveys and of broader surveys on use of health care, such as the study on reducing barriers to basic services in Mali. (For a report on this study, see the reference to Gamble Kelley et al. in Annex 3.)
- Distinguishing between young people's use of modern and traditional private sector providers.
- Looking beyond pregnancy prevention and examining information from the AIDS prevention community.
- Paying more attention to the interaction between pharmacists and youth, or more generally, the interaction between those working the counters at retail outlets selling condoms and the youth purchasing them.
- Disaggregating the analysis by marital status and sex.
- Putting research tools into the hands of youth, following the example of videocams used in antismoking campaigns.

*Examine potential as well as existing sources of care.* Certain categories of private health workers, such as nurse-midwives, do not yet serve adolescents in large numbers, but may have the potential and may be moving in that direction. We need to follow up efforts such as the SEATS work in Zambia with nurse-midwives.

*Push for more information from the DHS, but don't expect it to be a panacea.* The Demographic and Health Surveys can be refined, but will never give as much information as a youth-focused survey. We can encourage the DHS to oversample youth, but this can be very expensive.

*Better exploit the private sector as a source of information.* Information is as important to young people as services. Normalizing the discussion of adolescent sexual health via television and other mass media is also important as a precursor to providing information and services. We should support groups in developing countries that are already trying to work with the media to insert positive messages on reproductive health into commercial programming.

*Don't ignore the younger youth.* We need age-appropriate strategies for kids 10 to 14 years old. For example, younger kids also watch television programs that might be aimed at a slightly older age-group.

*Find out more about workplace HIV/AIDS prevention efforts.* There is a great deal of interest in fighting HIV/AIDS through the workplace, but we need to carefully examine the new programmatic models and make sure the field has fully absorbed the lessons from earlier workplace successes and failures. A meeting to examine workplace programs more generally may be one step toward achieving this goal.

*Examine more closely strategies to promote condom use by youth.* We need to know better how to promote condom use and how to destigmatize and normalize condom use. The private sector—both subsidized and unsubsidized—would play a big role in this effort.

*Use a multifaceted approach.* We do not yet know enough about the various commercial approaches to say which is more cost-effective in reaching youth. However, a multipronged approach involving several reinforcing activities, including those that change the social environment, may be the most effective. The characteristics of the youth population and the level of development of the commercial sector will, to a large extent, dictate the emphasis of program efforts in any particular country.

On a final note, participants agreed on the need to disseminate more widely the information exchanged at the dialogue and to continue discussions on youth and the private sector. A specific suggestion was made to organize a presentation at USAID on the forthcoming results of the CMS surveys on youth and private sector providers in Jamaica.

# **Annexes**

- 1. Meeting Agenda**
- 2. Participants**
- 3. Key Documents List**
- 4. Presentations and Handouts**

**ANNEX 1: Agenda**  
FOCUS on Young Adults Partner Dialogue  
***Social Marketing and other Commercial Approaches  
to Improving Adolescent Reproductive Health***  
February 15, 2001

- 8:30 - 9:00 *Coffee and sign-in*
- 9:00 – 9:10 *Welcome and review of objectives* (Lindsay Stewart, Deputy Director, FOCUS on Young Adults)
- 9:10 – 10:15 *The commercial sector's potential to meet adolescent reproductive health needs*
- 9:10 -- 9:20 *Presentation: Where adolescents go for services and what they will pay.* (Nancy Murray, Policy Advisor, FOCUS on Young Adults)
- 9:20 – 10:15 *Discussion*
- 10:15 – 10:30 *Coffee break*
- 10:30 – 12:30 *The range of commercial approaches to meeting adolescent reproductive health needs*
- 10:30 – 11:30 *Panel presentation*
- Part I: Providing information and services through the commercial sector**
- Social Marketing --HIV/AIDS prevention in Indonesia* (Reed Ramlow, Futures Group)
- Private Health Providers –Private-practice nurse-midwives in Zambia* (Tim Williams, JSI)
- Part II: Tapping the commercial sector for funding and expertise**
- Business Coalitions – The Global Alliance for Workers and Communities* (Kevin Quigley, International Youth Foundation)
- Working with the Media – The Media Project* (Debra Hauser, Advocates for Youth)
- Media Collaboration – Andrea Project, Peru* (Patricia Poppe, Johns Hopkins University, Center for Communication Programs)
- 11:30 – 12:30 *Discussion*
- 12:30 – 1:00 *Action recommendations*
- 1:00 – 2:00 *Lunch and informal discussion*

**ANNEX 2: Participants**  
**FOCUS on Young Adults**  
**Partner Dialogues 2001**

***A Dialogue on Social Marketing and Other Commercial Approaches  
to Improving Adolescent Reproductive Health***  
**February 15, 2001**

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### *ANNEX 3:Key Documents*

*This list includes publications that describe efforts to apply commercial approaches to adolescent reproductive health programming. It does not include the broader literature on the private for-profit role in health provision or the (even broader) literature on adolescent reproductive health programming.*

Agha, Sohail. "An Evaluation of Adolescent Sexual Health Programs in Cameroon, Botswana, South Africa, and Guinea." PSI Research Division Working Paper no. 29. Washington, DC:PSI, 2000.

Commercial Market Strategies Project. "Adolescent Behavior and Sources of Services in Jamaica." Washington, DC: CMS Project, forthcoming 2001.

Gamble Kelley, Allison, Edward Kelley, Cheick Simpara, Ousmane Sidibé, and Marty Makinen. "Reducing Barriers to the Use of Basic Health Services: Findings on Supply, Demand, and Quality of Care in Sikasso and Bla (Mali)." Bethesda, MD: Partnerships for Health Reform Project, Abt Associates, Inc., February 2001.

Harris, John. "Tsa Banana, Botswana. Social Marketing of Reproductive Health Services to Youth." *Project Highlights Series*. Washington, DC: FOCUS on Young Adults Program, 1999.  
(<http://www.pathfind.org/Project%20Highlights/Tsa%20banana.htm>)

Israel, Ronald C. and Reiko Nagano. *Promoting Reproductive Health for Young Adults through Social Marketing and Mass Media: A Review of Trends and Practices*. Washington, DC: FOCUS on Young Adults Program, 1997. (<http://www.pathfind.org/RPPS-Papers/Social%20Marketing.html>)

Kusanathan, T. and Keiji Suzuki. "Marketing Good Health. Zambia Urban Sexual Behaviour and Condom Use Survey 1999." Zambia: Society for Family Health and Population Services International, 2000.

Machaieie, Sonia and Jill Schumann. "Mozambique: Communications and Marketing for AIDS Prevention III. Consumer Profile Survey Report." Washington, DC: Population Services International, January 2001.

Meekers, Dominique. "The Implications of Free and Commercial Distribution for Condom Use: Evidence from Cameroon." PSI Research Division Working Paper no. 9. Washington, DC: Population Services International, 1997. (<http://www.psiwash.org/perl/store/commerce.cgi>)

Meekers, Dominique, Ghyasuddin Ahmed and M. Tinah Molatlhegi. "Understanding Constraints to Adolescent Condom Procurement: The Case of Urban Botswana." PSI Research Division Working Paper no. 12. Washington, DC: PSI, 1997.  
(<http://www.psiwash.org/perl/store/commerce.cgi>)

Murray, Nancy, Bill Winfrey, Charlotte Colvin, and Christine Stevens. "Will Adolescents Be Differentially Affected by User Fees for Reproductive Health Services?" Washington, DC: The Futures Group International. Draft. March 23, 2001.

Population Reference Bureau. *Social Marketing for Adolescent Sexual Health Results of Operations Research Projects in Botswana, Cameroon, Guinea, and South Africa*. Washington, DC: PRB, 2000. (<http://www.measurecommunication.org/reports/smash>)

Population Services International. "Research Report. Zimbabwe Condom Social Marketing Expansion Project. Knowledge, Attitudes and Practices Survey. 1999." Zimbabwe: PSI, 1999.

Senderowitz, Judith and Christine Stevens. "Leveraging the For-Profit Sector in Support of Adolescent and Young Adult Reproductive Health Programming." Washington, DC: The Futures Institute for Sustainable Development, forthcoming 2001.

***ANNEX 4: Presentations and other handouts by participants  
(attached)***

**Presentations**

1. "Potential of the Private Sector to Meet Adolescent Reproductive Health Needs." Nancy Murray, FOCUS.
2. "HIV/AIDS Prevention Project (HAPP). Partnership with Condom Manufacturers Helps Boost Condom Use in Indonesian Red Light Areas." Reed Ramlow, The Futures Group International.
3. "SEATS Subproject with Zambian Nurses Association." Tim Williams, John Snow, Inc.
4. "Global Alliance." Kevin Quigley, Global Alliance for Workers and Communities.
5. "Foundation wants TV shows to talk about sex—responsibly." Debra Hauser, Advocates for Youth.
6. "Andrea (Time for Love). Teenagers' Sexuality Hits Mainstream Media in Peru. How Did It Happen?" Patricia Poppe, Center for Communications Programs, Johns Hopkins University.

**Additional Handouts**

1. "Summary of Commercial Market Strategies (CMS) Adolescent Reproductive Health Initiative."
2. "Partnerships for Health Reform. Equity Initiative in Mali. Executive Summary."

Potential of the Private Sector to  
Meet Adolescent Reproductive  
Health Needs

FOCUS on Young Adults,

Partner Dialogues

February 15, 2001

## FOCUS on Young Adults: Priority Areas for Secondary Data Analysis

### I. Descriptive Patterns

#### A. Young Adults' Sexual Experience

- Age at sexual debut by sub-populations and overall
- Use of contraception at first/last sexual experience (ever and consistent use)
- Conditions of first and subsequent sexual experiences (type of partner, voluntary, etc.)

#### B. Young Adults' Utilization of Reproductive Health Services

- Source (public sector, NGO sector, commercial sector)
- STI and Pregnancy Prevention Levels (condom and other contraceptive method use)
- Patterns of sub-populations

### II. Explanatory Factors

#### A. Early Sexual Debut and Unprotected Sexual Experience(s)

- Other risk behaviors (smoking, drinking, drug use)
- Type of sub-population
- Familial, Peer/Partner, School, Community contexts
- Access to Services (physical, financial, attitudinal)

#### B. Utilization of Reproductive Health Services (Barriers to Use)

- Costs/Prices
- Official Policy/Norms
- Service Provider Attitudes/Resistance
- Configuration of Services

# **FOCUS on YOUNG ADULTS**

**FOCUS/Policy Approach to Understanding the Potential Role of the Commercial Sector: Use Existing Data to Understand Current Market Segmentation and Potential Targets**

- 1) Secondary Analyses of DHS Data to Identify Existing Patterns in Adolescent and Young Adults' Sources of Contraception and the Significant Determinants of Adolescents and Young Adults' Choices of Source
- 2) Secondary Analyses of Existing Data Examining Willingness to Pay Fee Increases

# **FOCUS on Young Adults**

- Using DHS Data to Identify Existing Patterns in Adolescent and Young Adults' Sources of Contraception

## Adolescents and Young Adults' Union Status and Levels of Sexual Activity as Reported in Selected DHSIII Surveys

	In Union	Single and Sexually Active Single	Total Sexually Active (In Union + Single, Sexually Active)	Total 15-24 Year Olds
	%	%	%	(n)
<b>Africa</b>				
Kenya	38.7	40.4	63.4	3394
Burkina Faso	56.3	28.6	68.8	2657
Togo	41.9	58.7	76.0	3221
<b>Asia</b>				
Bangladesh	100	na	100	3134
Philippines	26.1	1.4	27.1	5190
Indonesia	100	na	100	5144
<b>Latin America and the Caribbean</b>				
Bolivia	30.6	15.7	41.5	4370
Guatemala	49.9	5.1	52.5	2534
Nicaragua	51.9	3.7	53.7	5800

# FOCUS on YOUNGER ADULTS

## Proportion of Sexually Active Using Modern Methods, by Union Status

	15-24 Year Olds	
	Single	In Union
<b>Africa</b>		
Kenya	12.3	20.2
Burkina Faso	39.3	5.6
Togo	18.5	5.3
<b>Asia</b>		
Bangladesh	na	31.1
Philippines	5.8	19.7
Indonesia	na	46.9
<b>Latin America and the Caribbean</b>		
Bolivia	8	16.5
Guatemala	4.7	10.9
Nicaragua	11.1	38.2

# FOCUS ON YOUNG ADULTS

## Sexually Active Adolescents and Young Adults\*\* Use of the Private Sector\*\* as a Source of Contraception in Selected DHS/III Surveys

% 15-24 Year Olds  
Using Modern Methods  
That Obtain them in the  
Private Sector

<b>Africa</b>	
Kenya	41.3
Burkina Faso	44.4
Togo	36.4
<b>Asia</b>	
Bangladesh	73.4
Philippines	17.4
Indonesia	55.6
<b>Latin America and the Caribbean</b>	
Bolivia	50.6
Guatemala	63.2
Nicaragua	37.3

\* Who report being current users of modern contraception

\*\* Private Sector includes: NGOs, Private sector hospitals and clinics, pharmacies and shops, friends and family members, which can be a fairly large source for youth in some countries.

**Sexually Active Adolescents and Young Adults\*\* Use of the Private Sector\*\* as a Source of Contraception in Selected CDC Young Adult Surveys \***

	Women			Men		
	In Union	Single	All	In Union	Single	All
Romania	-	-	65.7	-	-	86.3
Ecuador	-	-	74.63			
Dominican Republic	-	-	51.09			
Chile	37.6	44.2	-	35.5	34.6	-

\* note: urban samples

### **Summary: Preliminary Results of Secondary Analyses Examining Adolescents and Young Adults' Contraceptive Utilization Patterns**

- Large proportions of 15-24 year olds are sexually active\*
- Use of modern contraception by the sexually active is generally low, with significant differences in some countries by union status
- Use of the private sector, including the commercial sector is high:
  - in 4/9 countries, the private and commercial sector has 50% or more of the adolescent and young adult "market"
  - in 4/9 countries, the private sector accounts for 30-40% of the "market"
- Great potential role for the private and commercial sector, especially if modern contraceptive use can be encouraged among the sexually active.

\*Sexually active: Has had intercourse at least once

**FOCUS on Young Adults**

- Are Adolescents Differentially Affected by User Fees?

# FOCUS ON YOUNG ADULTS

## Rationale

- Decreased or stagnant donor funding and trend towards privatization has led to implementation of user fees
- Increased attention to young adult reproductive health issues
- Lack of information on adolescents' use of services when user fees are charged. Policy makers and program managers need this information to make decisions about cost recovery.

# FOCUS on Young Adults

## Data

**ECUADOR** (n= 5411)

Age 15 to 19 (n=254 )

Age 20 to 24 (n=1468 )

Age 25 + (n=3689 )

Clients of CEMOPLAF who attend clinic for general OB-Gyn check up

**EGYPT** (n=1688)

Age 15 to 19 (n=28 )

Age 20 to 24 (n=252 )

Age 25 + (n=1408)

Clients of public sector and NGO clinics for family planning methods

**MALI** (n=504)

Age 15 to 19 (n=56)

Age 20 to 24 (n=142)

Age 25 + (n=306)

Women who buy contraceptive methods from public and private distributors

## **METHODS**

- Secondary analysis of existing data
- Logistic regression
  - Effects of age, union status, residence, education, income (ability to pay) and other factors on women's willingness to pay more than current price for services

# FOCUS ON YOUNGER ADULTS

## Ecuador: Logistic Regression Results

Variable	Odds Ratio*
<b>Age</b>	
15-19	1.15
20 to 24	1.15*
(25+)	1
<b>Marital Status</b>	
(Not Married)	1
Married	0.81**
<b>Completed Educational Level</b>	
(None)	1
Primary	1.48**
Secondary	1.39*
Higher Education	1.45*
<b>Income (Ability to Pay)</b>	
(Low)	1.0
Medium	1.15*
High	1.31***
<b>Price Paid for Service</b>	
(Median or Less)	1
More than Median	0.84**

\* p < .05, \*\* p < .01, \*\*\* p < .001

# FOCUS ON YOUNG ADULTS

## Egypt: Logistic Regression Results

Variable	Odds Ratio*
Age	
15 to 19	1.16
20 to 24	0.89
(25+)	1
<b>Residence</b>	
(Rural)	1
Urban	1.19
<b>Education</b>	
(None)	1
Primary complete	0.76
Secondary complete or more	1.11
<b>Ability to Pay (Expenditures made for meat in household)</b>	
(Low)	1
Medium	1.21
High	1.51**
<b>Price paid for Method</b>	
(Median or less)	1
Higher than Median	0.39***

\* p < .05, \*\* p < .01, \*\*\* p < .001

# FOCUS on YOUNGER ADULTS

## Mali: Logistic Regression Results

Variable	Odds Ratio*
<b>Age</b>	
15-19	0.90
20-24	1.36
(25+)	1
<b>Marital Status</b> (Not Married)	1
Married	0.42*
<b>Residence</b> (Rural)	1
Urban	2.41*
<b>Education</b> (none)	1
Primary or more	1.13
<b>Ability to Pay (Household Assets)</b> (Low)	1
Medium and Higher	1.38
<b>Price Paid for Method</b> (Median or Less)	1
More than Median	3.87***

\* p < .05, \*\* p < .01, \*\*\* p < .001

# FOCUS ON YOUNG ADULTS

## Preliminary Summary Results

	PREDICTOR	OUTCOME
ECUADOR	Age 20 to 24	↑ WTP
	High Education	↑ WTP
	High Income	↑ WTP
	In-Union	↓ WTP
	Paid More than Median Price	↓ WTP
EGYPT	Age	No difference
	Income (expenditure on meat)	↑ WTP
	Paid more than median price	↓ WTP
	Used IUD or injectable	↓ WTP
MALI	Age	No difference
	Household owns car or television/urban Residence	↑ WTP

In Union  
Paid more than median price

↓ WTP  
↑ WTP

## Preliminary Conclusions

- Neither adolescents nor young adults are less willing to pay price increases as compared to women 25+
- Income is directly related to willingness to pay higher prices for services
- Women in union are less willing to pay increases than single, sexually active women (implications for youth)
- Current costs of specific services, other costs, and residence, among other factors, need further examination

# **FOCUS ON YOUNG ADULTS**

## Future Directions

- Study adolescents and youth who are not using services and how cost affects decision to use a service or not
- Include young men in future studies
- Think about how to measure income for young people.
- Over-sample youth, especially 15 to 19 year olds.