

PARTICIPANT RESOURCE

**EVIDENCE INFORMED
PRACTICES (EIPS)**



EVIDENCE-INFORMED PRACTICES (EIPS)

MAKE SERVICES ADOLESCENT- AND YOUTH-FRIENDLY

THE PRACTICE

Take young people's specific needs into account, providing age- and developmentally-appropriate contraception and reproductive health services.

WHY IT MATTERS

One size does not fit all. Young people can vary substantially in their life experiences. The term “adolescents and youth” encompasses young people, ages 15–24, who may be...

- + Just beginning to explore relationships
- + Unmarried or married
- + Without children
- + First-time parents
- + Parents to multiple children

The term also includes young people who may be living with HIV, have access to health information and supportive parents, or struggle to make sense of their feelings with little information or support.

ADOLESCENT- AND YOUTH-FRIENDLY SERVICES FOR BOTH YOUNG MEN AND WOMEN COMMONLY INCLUDE:

- + Safe and affordable contraceptive methods
- + Prevention and treatment of HIV/AIDS and care for other STIs
- + Provision of accurate health information
- + Sensitive counseling and care for overall well-being

SERVICES MAY ALSO INCLUDE:

- + Youth-friendly obstetric and antenatal care for pregnant girls and women
- + Post-abortion care
- + Prevention, detection, and counseling for gender-based violence
- + Prevention, detection, and treatment for cervical cancer

FEATURES OF ADOLESCENT-FRIENDLY SERVICES

- 1. ACCESSIBLE:** Adolescents are able to obtain the health services that are available.
- 2. ACCEPTABLE:** Adolescents are willing to obtain the health services that are available.
- 3. EQUITABLE:** All adolescents, not just selected groups, are able to obtain the health services that are available.
- 4. APPROPRIATE:** The right health services (i.e. the ones they need) are provided to them.
- 5. EFFECTIVE:** The right health services are provided in the right way, and make a positive contribution to their health.

SUGGESTED ACTIVITIES

Based on WHO's global standards for youth-friendly services, health facilities should strive to:¹

- 1. Ensure adolescents are knowledgeable** about their own health—and where and when to obtain health services—putting new systems in place, if needed.
- 2. Ensure community support.** Parents, guardians and other community members and community organizations should recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
- 3. Provide an appropriate package of services.** The health facility provides a package of information, counseling, diagnostic, treatment and care services that fulfills the needs of all adolescents. Services are provided in the facility and through referral linkages and community-based outreach.
- 4. Promote health providers' competencies.** Healthcare providers should demonstrate the technical competence required to provide effective health services to adolescents. Both health care providers and support staff should respect, protect, and fulfill adolescents' access to information, privacy, confidentiality, non-discrimination, and non-judgmental care and respect.
- 5. Promote “welcoming” health facilities.** The health facility should have convenient operating hours, keep a welcoming and clean environment, and maintain privacy and confidentiality. It should have the equipment, medicines, supplies, and technology needed to ensure effective service provision to adolescents.
- 6. Guarantee equity and non-discrimination.** The health facility should provide quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, or other characteristics.
- 7. Collect data to improve quality.** The health facility should collect, analyze, and use data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff should be supported to participate in continuous quality improvement.
- 8. Enable adolescents' participation.** Adolescents should be involved in the planning, monitoring, and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

IMPLEMENTATION CONSIDERATIONS

Youth-friendly care can be delivered using a range of service delivery models: care can be either stand-alone (such as a separate clinic or dedicated space for youth) or they can be integrated and mainstreamed into the primary care normally provided by health facilities, through mobile outreach, or as part of community-based care, including home-based care. Thinking outside the separate space: a decision-making tool for designing youth-friendly services provides guidance in selecting and adapting appropriate youth-friendly care models based on the country context, target population, and desired behavioral or health outcomes. Youth centers (i.e. independent facilities that provide a range of programs and services to adolescents and youth such as recreational, vocational, or cultural activities which may also host a dedicated room where health care providers can offer RH/FP information and care), have not been shown to be effective at increasing adolescent and youth uptake and use of RH/FP services.

The provision of AYRH services should be firmly grounded in the principles of equity, non-discrimination, and voluntarism, stressing that quality information and services must be available to all adolescents and youth. Equitable adolescent- and youth-friendly services ensure that no policies and procedures restrict the provision of health services to marginalized or vulnerable adolescents.

Marginalized or vulnerable adolescents and youth are those who are more likely to lack adequate care and protection. Segmentation analysis is an important step in identifying and understanding these specific sub-groups and their needs. These can then be factored into the development of equitable and inclusive AYRH care and programs. Having dedicated health service delivery points for marginalized and stigmatized groups may help reach vulnerable adolescents and youth, as part of a complementary segmentation strategy.

A variety of tools exist to aid in the implementation of AYRH care. For example, the 2015 WHO Global Standards for Quality Health-Care Services for Adolescents is a guide intended to assist program and facility managers, providers, national bodies, and other individuals and organizations who provide adolescent healthcare, to improve the quality of health care services, so adolescents' needs can be better met. The quality standards in the tool are accompanied by implementation and monitoring guidance.

Finally, it is important to note that not all health facilities or health systems have enough capacity to ensure consistent, high-quality AYRH care. Depending on the life stage of the individual, a young person may require additional provider time, support, information, and counseling than can be offered by fragile health systems, which may lack sufficient human resources for health, or adequate

space to ensure privacy. But all providers, regardless of context, can be sensitized to provide a welcoming and safe environment.

PROGRAMMATIC EXAMPLE

To address the challenges that adolescent girls and young women face in seeking HIV and reproductive healthcare, the Girl Power-Malawi project tested a variety of integrated approaches to facilitate service uptake. The project compared the current standard of care offered by public-sector health centers—which consisted of vertical HIV testing, family planning, and sexually transmitted infection management in adult-oriented spaces, by providers without extra training—with public sector facilities offering three different models of youth-friendly health services. These included 1) a “standard” youth-friendly service (YFS) package, with trained providers, a dedicated space, and peer education, 2) the YFS package plus a behavioral intervention (BI), which consisted of a curriculum-guided small group education session, and 3) the YFS package, plus the behavior intervention, plus conditional cash transfers. The findings of the study revealed that the youth in the YFS models, considered together, were 23% more likely to receive HIV testing, 57% more likely to receive condoms, and 39% more likely to receive hormonal contraception.



EVIDENCE-INFORMED PRACTICES (EIPS)

SUPPORT CONTRACEPTIVE CHOICE

THE PRACTICE

Provide quality counseling and a full range of methods, including long-acting and reversible contraception, to ensure young people can choose a method that aligns with their preferences and goals.

WHY IT MATTERS

Sixteen million adolescents (ages 15–19) give birth each year. Most live in low- and middle-income countries. Many of these pregnancies are unintended. Others are mistimed. Twenty-three million adolescents would like to use contraception but currently do not. Early and mistimed pregnancies may result in maternal morbidities and death, and lead to social consequences that limit the potential of young women.

Many barriers exist for adolescents who may want to use contraception to delay a first pregnancy or space subsequent pregnancies—restrictive laws limiting contraceptive choice, poorly implemented policies, and social norms, including beliefs held by providers and communities about what kinds of contraception, if any, are appropriate for young people. Compounding these issues, young people may not know where to get affordable contraception, may feel stigmatized due to their own sexual behavior, may not have a choice, or, in the case of marriage, may feel pressure to demonstrate their fertility.²

Adolescent and youth reproductive health (AYRH) services related to contraception have quality counseling as their centerpiece. The objective of this counseling is to ensure that young people are aware of the voluntary nature of contraceptive use and knowledgeable of the full range of contraceptive options available to them.

Quality counseling, including expanded method choice, should empower young people to choose their preferred method and switch methods should they experience undesirable side-effects. Expanding contraceptive choice aligns with the World Health Organization's third norm for improved quality of healthcare for adolescents (WHO, 2015).³ Any adolescent can use any contraceptive method according to the WHO's Medical Eligibility Criteria for contraceptive use. Age alone does not constitute a contraindication to the use of contraceptive methods.

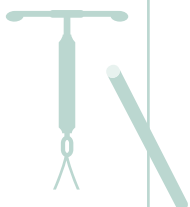
A FULL RANGE OF CONTRACEPTIVE METHODS FOR YOUNG PEOPLE SHOULD INCLUDE THE FOLLOWING:

- + **Long-acting, reversible methods (LARCs)**, such as contraceptive implants and intrauterine devices (IUDs)
- + **Short-term contraceptives**, such as injections, combined oral contraceptive pills, and progestin-only oral contraceptives
- + **Barrier methods, such as male condoms and female condoms**
- + **Lactational Amenorrhea Method (LAM) method**
- + **Emergency contraceptive pills**
- + **Fertility awareness**

SUGGESTED ACTIVITIES

The following activities promote expanded contraceptive choice for adolescents and youth:

- + **Ensure the availability of a full range of contraceptive methods.**
 - Establish an effective system for providing a full range of contraceptive products—to enable young people to choose, access, and use the best contraceptive method for their needs, thus minimizing discontinuation and improving satisfaction.
 - Address provider misconceptions and biases as needed to ensure providers are aware of and able to provide the full range of contraceptive methods to young people.



SPOTLIGHT ON LARCS

While most AYRH programs provide barrier and short-term contraceptive methods, there is little to no emphasis on improving young people's access to, and use of, LARCs—one of the most effective contraceptive methods. This is often due to bias or lack of knowledge on the part of health care providers, who may perceive LARCs to be more appropriate for older women and couples who wish to space or limit their pregnancies.

LARCs are especially useful to adolescents and youth because of their lower rates of method discontinuation or user error. In addition to their effectiveness and ease of use, LARCs can help address youth concerns about privacy and confidentiality, since they require little user follow-up and are long-lasting.

GET MORE INFORMATION from The Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting and Reversible Contraception.⁴

+ Ensure service providers have the required competences to deliver youth-friendly contraceptive services.

- Train health care providers on contraceptive technologies, including those related to LARCs, the WHO medical eligibility criteria for contraceptive use; and WHO provider competencies for adolescent and youth friendly services.
- Conduct values clarification exercises to address provider bias.
- Provide pre-service and in-service training for health care providers on adolescent- and youth-friendly services.
- Provide supportive supervision, mentorship programs, and job aids to encourage providers to deliver youth-friendly services.

+ Enable adolescents and youth to access information and counseling on a full range of contraceptive methods.

- To ensure informed choice, provide comprehensive information and counseling that:
 - *focuses on the unique concerns and needs of adolescents and youth*
 - *considers their fertility intentions*
 - *addresses myths and misconceptions*
 - *promotes body literacy, which is essential for effective contraception use and is the cornerstone of empowerment in the context of family planning/reproductive health*
- Ensure counseling services protect young clients' confidentiality and privacy.
- Using the WHO Medical Eligibility Criteria, ensure young clients do not have any medical issues that may prevent them from using specific contraceptive methods.

+ Create an enabling environment that encourages adolescents and young people to make their own choices related to contraception.

- Ensure community support for young people's demand of, access to, and use of the full range of contraceptive methods.
- Support laws, policies, and guidelines that guarantee all access to contraceptive information, products, and services for all adolescents and youth.
- Implement interventions to address gender norms that limit young people's contraceptive use.

IMPLEMENTATION CONSIDERATIONS

While most AYRH programs provide barrier and short-term contraceptive methods, there is little to no emphasis on improving their access to, and use of, LARCs. This is often due to bias or lack of knowledge on the part of health care providers, who may perceive LARCs to be more appropriate for older women and couples who wish to space or limit their pregnancies. LARCs are among the most effective contraceptive methods, short of sterilization and abstinence. Typically, out of 100 women using a contraceptive implant, less than 1 (0.05%) becomes pregnant within the first year. The intra-uterine device (IUD) is equally effective, with less than 1 pregnancy per 100 users (0.08%) within the first year. Both forms of contraception provide similar levels of long-term protection, ranging between 3 and 10 years, depending on the method. Conversely, short-acting methods result in more unintended

pregnancies, between 6 to 12 pregnancies per 100 women per year. Barrier methods are even less effective, leading to 18 or more unintended pregnancies per 100 women in a year.

LARCs are especially useful to adolescents and youth because of their lower rates of method discontinuation or user error. In addition to their effectiveness and ease of use, LARCs can help address youth concerns about privacy and confidentiality, since they require little user follow-up and are long-lasting.

Increasing the number and diversity of family planning service delivery points is another way to expand contraceptive choice and increase the uptake of family planning methods. Young people may feel intimidated to access services at health facilities. Thus, increasing access at the community level, through community-based distribution or pharmacies/drug shops, for example, will also increase contraceptive uptake.

PROGRAMMATIC EXAMPLE

To address the issue of the low uptake of LARCs among Ethiopian youth, the 'LARCs and Youth' project was launched to promote an expanded method mix for all young women at Youth Friendly Service (YFS) units in selected health centers in Amhara and Tigray regions. The project utilized a two-pronged approach: 1) service delivery limited to LARCs training for the YFS providers and the provision of supportive supervision; and 2) peer-led demand creation and awareness-raising activities focused on LARCs, myths, and misconceptions. This intervention was compared to the standard level of care in a convenience purposive sample of 20 youth friendly health units; ten each in Amhara and Tigray regions, Ethiopia; randomly allocated to the intervention (five) and non-intervention (five) arms. The results revealed that training youth friendly service providers to counsel and provide all contraceptive methods including LARCs in one location resulted in significantly higher LARCs uptake among young women; including those planning on delaying their first pregnancy.



EVIDENCE-INFORMED PRACTICES (EIPS)

COORDINATE ACROSS SECTORS

THE PRACTICE

Make plans for collaboration among sectors (e.g. health, education, environment, economy) and with key stakeholders (e.g., government, civil society, and private sector) to improve adolescent and youth reproductive health (AYRH).

WHY IT MATTERS

The advantages of multi-sectoral coordination, if thoughtfully and carefully done, can achieve a policy outcome, such as increasing resources brought to bear to address a health problem. These resources can include:

EXPERTISE

- + **Human resources**
- + **Material and financial resources**
- + **Greater coverage of programs**
- + **Increased social and political support for solutions**

AYRH challenges are complex, implicating social norms, education, economic disparity, gender inequality, and environmental factors.⁵ The response to AYRH challenges must be equally comprehensive. Well-planned, thoughtful multi-sectoral coordination can provide a holistic approach to addressing AYRH issues and help increase the probability of the success of the response.

Evidence suggests programs that are implemented in a coordinated way across multiple sectors are more effective in realizing adolescents' health and wellbeing⁶ and contributing to the realization of the objectives of the economic and education sectors of society.⁷ A recent systematic review to identify insights and evidence gaps in girl-centered programs suggests that multi-sectoral programs tend to outperform single-sector programs.⁸

KEYS TO PLANNING SUCCESSFUL MULTI-SECTORAL COLLABORATION

- + **A comprehensive, contextual understanding of the problem**
- + **Recognition of the value of engaging diverse stakeholders** from various sectors in the policy process and capitalizing on the particular strengths of individual stakeholders

- ✦ **Buy-in and commitment from all stakeholders**
- ✦ **Strong leadership**—to set the agenda, manage relationships, and mobilize stakeholder action
- ✦ **The ability to effectively tailor messages and approaches** to each stakeholder to increase influence
- ✦ **Communication of the benefits of collaboration** to each sector and partner to jointly achieve the priority AYRH goal
- ✦ **Commitment of adequate resources** to ensure capacity building, effective cross-sectoral linkages, and coordination between sectors at every level of implementation

The probability of the success of multi-sectoral collaborations increases substantially when it is supported, highly incentivized, or mandated.

SUGGESTED ACTIVITIES

The following approaches for effective multi- and inter-sectoral coordination are recommended by the World Health Organization, West African Health Organization, the Lancet Commission on Adolescent Health and Wellbeing:

- ✦ **Adopt evidence-based multidisciplinary and multi-sectoral approaches**⁹ that engage the education, youth, media, finance, justice, and social protection sectors to create a systematic package of complementary services that build on one another's strengths and enhance synergies.
- ✦ **Involve multiple sectors in steering and technical committees that serve youth in the development of national youth policies and strategies, including AYRH.** National strategies are more likely to be effectively implemented if all relevant sectors have participated in developing them and negotiating for their adoption. WAHO recommends that the process of developing a national adolescent and youth health strategy should start with identifying, mapping, and coordinating with all adolescent actors, including AYRH, in the country.¹⁰
- ✦ **Build the capacity of key AYRH actors to ensure that multi- and inter-sectoral interventions are efficient and effective.** Inter- and cross-sectoral programs and interventions are complex and require that each sector be technically competent and able to manage and coordinate their programs and investments.¹¹
- ✦ **Establish transparent, user-friendly monitoring and evaluation systems and clear accountability mechanisms.** The Global Strategy for Women's Children's and Adolescents' Health highlights the importance of transparent and accessible data to ensure effective inclusion of stakeholders beyond health care providers.¹² Effective inter-sectoral coordination for AYRH requires easy access to quality data. Transparent access to data will ensure all stakeholders, including young people, are able to monitor progress and hold decision-makers to account.

IMPLEMENTATION CONSIDERATIONS

Many factors must be taken into consideration in planning for a successful multi-sectoral collaboration. A comprehensive, contextual understanding of the problem is required. Buy-in and commitment from the stakeholders is essential.

Strong leadership, to set the agenda, manage relationships, and mobilize stakeholder action, is critical. In addition, the following competencies are important for success: 1) the capability to recognize the value of engaging diverse stakeholders from different sectors in the policy process and capitalize on the particular strengths of individual stakeholders, 2) the ability to effectively tailor messages and approaches to each stakeholder to increase influence, and (3) the capacity to communicate the benefits of the collaboration to each sector (e.g., health, labor, economy, education) and partner (government, bilateral donors, nongovernmental organizations and other private partners) of working together to jointly achieve the priority AYRH goal.[6] While a cross-sectoral strategy can maximize opportunities and organizational strengths, it requires a commitment of adequate resources to ensure capacity building, effective cross-sectoral linkages, and to ensure the processes that enable coordination between sectors at every level of implementation are executed. Though often left unstated, the probability of the success of multi-sectoral collaborations increases substantially when it is supported, highly incentivized, or mandated.

PROGRAMMATIC EXAMPLE

Programa Geração Biz (PGB) is a multi-sectoral collaboration which aims to improve the reproductive health of adolescents in Mozambique. The program works to reach young people with reproductive health interventions in clinics, schools, and the community. The clinical component successfully integrated AYRH services into existing public-sector health facilities. This included trained staff, expanded and/or dedicated clinic hours for adolescents in a dedicated space, appealing IEC materials, peer educators in waiting areas, and the reduction of cost barriers. The school-based component involved both trained peer educators and selected teachers to provide RH/FP education and referrals to services in secondary schools. Finally, out-of-school youth were trained as community-based peer educators to reach out to youth missed by the school-based program. Responsibilities for the different components of the program were carefully defined. The clinical component was implemented by the Ministry of Health. School-based activities were implemented by the Ministry of Education. The Ministry of Youth and Sports spearheaded community-based activities to reach out-of-school youth. “Robust referral linkages were established between these three types of activities ensuring referrals from school-based and community-based interventions to local facility-based adolescent- friendly health services.”



EVIDENCE-INFORMED PRACTICES (EIPS)

CREATE PLATFORMS AND PROCESSES FOR MEANINGFUL YOUTH PARTICIPATION

THE PRACTICE

To ensure the relevance, responsiveness, and effectiveness of adolescent and youth reproductive health (AYRH) programming, it is critical to meaningfully engage and build the capacity of youth advocates and leaders.

WHY IT MATTERS

Through active participation, young people are empowered to play a vital role in their own development as well as in that of their communities, helping them to learn critical life skills, develop knowledge on human rights and citizenship, and promote positive civic action. Adolescent participation is one of WHO's eight standards that must be attained to improve the quality of health services for adolescents. Young people's participation must be understood as an essential component to be monitored and evaluated.¹³

KEY ELEMENTS OF YOUTH PARTICIPATION TO ADVANCE AYRH

- + **Youth with capabilities and opportunities to seek information**
- + **Youth who are able to express their opinions, ideas, and decisions**
- + **Youth informed and consulted on decisions** that pertain to youth (programs and policies)
- + **Youth who take an active role in the various steps** of designing, implementing, and monitoring a health service or policy
- + **Youth with the knowledge, skills, and desire** to make informed choices about their reproductive life
- + **Youth with the knowledge and skills** necessary to hold influential decision-makers accountable

Youth participation nurtures the skills that are vital for young individuals to promote a thriving civil society sector and functioning democratic institutions, including responsive health systems and services.

SUGGESTED ACTIVITIES

The following activities effectively build the capacity of youth advocates and leaders and create inclusive processes and platforms for youth participation:

- ✦ **Partner with a diverse range of youth networks, organizations, and individuals:** The term ‘youth’ masks the wide range of experiences, diversity, and needs of young people. Youth engagement efforts should be inclusive to ensure broad representation of perspectives.
- ✦ **Invest in youth leadership development:** Training, coaching, and mentorship efforts, along with capacity-building regarding political and management processes, are essential to effective youth participation.¹⁴
- ✦ **Support youth participation in AYRH advocacy.** The past two decades have seen increased youth engagement in health-related advocacy at the global, national, and community levels.¹⁵ In West Africa, the Young Ambassadors for Family Planning were established to ensure AYRH policies are responsive to their needs and perspectives. Young people need platforms to make sure their voices are heard and that they are able to participate in policy development, implementation and evaluation.
- ✦ **Partner with youth in the planning, monitoring, evaluation, and scale-up of AYRH services and programs.** Involving young people and empowering them as leaders, including as part of health facilities’ governance structures, adds value to programs and services and contributes to their sustainability¹⁶ The WHO recommends that health care facilities regularly seek adolescent feedback on the services they provide.¹⁷
- ✦ **Provide opportunities for youth participation in service provision and project implementation.** Participation opportunities include involvement in peer education and/or counseling programs, pre- and in-service training of providers in YFS delivery, and quality assessment of available services, among others. Peer programs are probably the most popular and documented approach. Evaluations of peer programs show that the greatest benefits accrue to the peer educators themselves,^{18,19} and are an excellent opportunity to build youth leadership skills, but only achieve modest results in improving the health of youth beneficiaries.^{20,21} Peer programs appear to be most effective when they capitalize the peer educators’ ability to disseminate information and refer young people to health services and when combined with other evidence-informed practices.
- ✦ **Ensure youth participation in research. Youth-led participatory action research is an increasingly popular way to promote youth engagement and empowerment.** Such youth-led research builds the research and engagement skills of young people, increases their knowledge of their own communities, and enables them to contribute to positive social change and the improvement of health in their communities.
- ✦ **Support and enable youth decision-making about FP/RH.** The health sector should develop and implement policies and guidelines that support adolescent decision-making and informed choice through the provision of accurate, appropriate, and easily understood information on the benefits, risks and alternatives to FP/RH products and services—including the full range of contraceptive methods.
- ✦ **Gather robust data on effective programming for young people,** including youth-led initiatives, and use this information to inform program design, implementation, monitoring, and evaluation as well as drive advocacy for programming that supports youth, leadership, and partnership.

IMPLEMENTATION CONSIDERATIONS

Cultivating and supporting meaningful youth engagement is a process that should begin at the very outset of an AYRH program. Young people should be partners in problem identification and assessment, program design, implementation, monitoring and evaluation, and advocacy.

It is important to be mindful of several issues when considering how best to ensure youth participation and leadership in AYRH programming. First, consideration should be given to the selection, recruitment, and retention of young people. What young people should be involved? Why? How does this choice reflect the objectives of the project? Remember that young people have different needs, skill levels, interests and backgrounds. For example, are there social inequalities as well as inequities of health service access and utilization that should be kept in mind? Also, marginalized and stigmatized youth may face special challenges in receiving equitable and non-discriminatory AYRH care and in participating in leadership opportunities.

Thought should be given to the level of youth involvement that is needed to build the kind of critical citizenry skills described above. How will the program involve young people and in what capacities? Will the program work with an already existing youth organization and help them implement their ideas? Youth participation can take many forms – from youth-led civil society action and advocacy, to ensuring youth have a role in governance, including oversight of government policies and programs.

It is also important to think about the capacity of the organization or program that wishes to engage youth. Is it prepared for this type of collaboration? Does it have the human and material resources to invest in the skill development of young people? Are there platforms and opportunities for young people to provide input and influence programming? Is it prepared to consider youth ideas, fora, and adjust programming accordingly? To participate effectively, young people must have the proper tools, such as information, education about, and access to, their civil rights. Meaningful youth engagement calls for partnerships between established stakeholders (e.g., governments, communities, institutions, development practitioners) and young people. Cultivating such partnerships takes time, commitment, and resources. These partnerships can provide young people with the training, tools, and platforms they need to be recognized and heard.

Finally, thought must also be given to the structure of the youth participation initiative to maximize broad and diverse involvement and continually cycle in new and fresh perspectives. Mechanisms should be put in place to recruit new cohorts of youth with time-bound commitment to ensure access to the diversity of perspectives and to avoid going back to the same young people

over and over again. Thought also needs to be given to the issue of proper compensation of youth involved in leadership, whether voluntary or paid. It is also important to have mechanisms in place that continually challenge young people to grow as their experience and ‘professionalization’ increases—to foster leadership, linkages to volunteer and professional opportunities, and to increase social and professional networks.

Finally, an organization should monitor and evaluate their youth involvement efforts. Sample quantitative and qualitative indicators for such monitoring and evaluation can be found in the publication, *Youth Participation Guide: Assessment, Planning, and Implementation*, a collaboration between FHI 360 and Advocates for Youth.

PROGRAMMATIC EXAMPLE

The Ishi Campaign in Tanzania was originally developed by HealthScope Tanzania in partnership with Johns Hopkins Center for Communications Program. The campaign aimed to promote communication about HIV and reproductive health among adolescents, especially couples. Involvement of the target audience in all components of the campaign was especially notable. Adolescents participated in the initial assessment and identification of priority themes, in the process of developing and pre-testing messages, implementing interventions (through the creation of community action teams to drive implementation) and monitoring messages in the community. The campaign aligned well with national government priorities and was deeply resonant and popular within the country. Cross-sectional research to assess Ishi’s impact revealed that there was a positive association between the level of exposure to the campaign and selected HIV-preventive behaviors. Just as importantly, many of the youth volunteers involved with Ishi utilized the skills they acquired during the course of the project and have grown professionally to become senior leaders and advisors for RH and HIV for local and international NGOs in Tanzania.



EVIDENCE-INFORMED PRACTICES (EIPS)

ADVANCE FAMILY LIFE EDUCATION

THE PRACTICE

Utilize a curriculum-based process to ensure young people are equipped with skills, knowledge, and values that will help them make choices for their health and wellbeing—and show respect for others' choices.

WHY IT MATTERS

Family Life Education is an effective, evidence-informed approach with the potential to:

- + Empower adolescents and youth
- + Improve and protect young people's health, well-being, and dignity
- + Support young people to develop critical thinking and decision-making skills
- + Promote citizenship
- + Foster equal, healthy and positive relationships

Family Life Education focuses on teaching and learning about the cognitive, emotional, physical, and social aspects of adolescence, growth and development, and relationships. There exists convincing evidence of the positive effect of Family Life Education on FP/RH, particularly in reducing the incidence of sexually transmitted infections, HIV, and unintended pregnancy.

KEY CHARACTERISTICS OF AN EFFECTIVE FAMILY LIFE EDUCATION PROGRAM

- + Scientifically accurate
- + Incremental (each lesson builds on the last)
- + Age- and developmentally-appropriate
- + Curriculum-based
- + Comprehensive—to ensure young people can make informed choices about their health
- + Based on a human-rights approach
- + Culturally relevant and context-appropriate
- + Gender-transformative (promoting gender equality)
- + Skills-focused

SUGGESTED ACTIVITIES

+ Build support for Family Life Education.

The ministries of health, education, youth, and gender play critical roles in providing policy and moral national leadership, which is essential in creating a climate that is conducive to Family Life Education.²² To garner support at every level, consider the following activities:

- Use evidence that demonstrates young people's existing needs within national and local contexts.
- Use existing international, regional, and local frameworks and international agreements that support Family Life Education.
- Identify key thought leaders to influence support for Family Life Education in their networks and beyond.
- Advocate for sufficient funding for the Family Life Education policy to successfully support its implementation and scale-up.

+ Involve a broad coalition of stakeholders in planning Family Life Education.

Ensure multiple constituencies are involved in planning and implementing Family Life Education programs. Coalitions may include school officials, teachers, health care providers, students, religious leaders, community leaders, parents, NGOs, and the media. Broad involvement will help to ensure that community concerns are addressed early in the planning process and that you build societal support for Family Life Education—including sustainability and a sense of ownership.

+ Ensure effective coordination.

National Family Life Education programs falter and sometimes fail due to insufficient coordination among stakeholders, including central and local governments, NGOs, and other development partners. Clarity about roles, including responsibility for the implementation of FLE, is vital.

+ Ensure the Family Life Education curriculum is responsive to local needs.

Sometimes, a national curriculum is not sufficiently responsive to local needs, especially in areas where there are considerable socio-demographic differences. Using a broad coalition of stakeholders in the planning and implementation processes will help to ensure the curriculum is responsive to local health priorities and in alignment with progressive social norms.

+ Ensure adequate monitoring and evaluation systems are in place.

Mechanisms for evaluating the effectiveness of teachers and assessing the impact of the program on students are important in the success of Family Life Education programs.

IMPLEMENTATION CONSIDERATIONS

UNESCO's global review of evidence, lessons and best practices reports that many countries who embrace the need for FLE are engaged in national efforts to institute school-based programs through the integration of FLE into national curricula, investment in monitoring its implementation, engaging communities and scaling-up of effective teacher training.

FLE is most effective when combined with other activities such as YFS provided in health facilities, as part of more comprehensive youth development programs, or through peer outreach. The success of FLE is largely determined by the context in which these programs are developed and the manner in which it is delivered especially in communities where adolescent sexuality is a sensitive issue.

The integration of a gender perspective throughout FLE curricula is integral to the effectiveness of the programs. There is evidence that curricula that examine, question, and critically engage gender norms are more effective than gender-blind approaches.

The decision to initiate a family life education program should not be solely motivated by its ability to achieve reductions in adverse health events alone. Rather, decision-makers should also consider that these programs have major non-health benefits such as reducing gender inequality, improving communication, strengthening the quality of relationships, increasing self-efficacy in decision-making, and reducing sexual violence.

PROGRAMMATIC EXAMPLE

Useful UNESCO resources include a series of case studies documenting various phases of planning for, and implementing, FLE. One case study highlights the experience of a Pakistani NGO, Aahung, which developed culturally appropriate strategies to respond to the community's RH/FP needs. The NGO successfully integrated its life skills-based education program into both public and private schools in Sindh province. An important component of this work was engaging with parents and community leaders to ensure local support for the project. Question and answer sessions were organized with parents, giving them the opportunity to express any concerns. Because of their Aahung's efforts, parents recognized the benefits of having Aahung's evidence-based curriculum which was delivered by trained professionals. Aahung found that "involving parents in this way increases support for the program and results in fewer barriers for the project's implementation."



EVIDENCE-INFORMED PRACTICES (EIPS)

FOSTER FAMILY AND COMMUNITY SUPPORT

THE PRACTICE

Collaborate with community groups and gatekeepers—e.g., young people’s parents and families—to address social norms and create a supportive environment to improve young people’s reproductive health.

WHY IT MATTERS

Restrictive social norms about AYRH make young people feel uncomfortable about their own behavior, inhibiting their access to knowledge, services, and ultimately healthy decision-making. On the other hand, supportive families and communities become important resources, helping young people grow and develop. Work with community groups and gatekeepers to challenge and change social norms and harness local systems and structure to provide a supportive environment for AYRH programs and young people to take action.

SUGGESTED ACTIVITIES

While there exists little documented evidence on community-based strategies that effectively result in increased support for AYRH, studies suggest promising outcomes when utilizing these practices:

- ✦ **Promote the participation of parents and parent-child communication.** There is often limited communication between adolescents and their parents about issues related to FP/RH, teenage pregnancy, HIV, and AIDS.²³ Several studies suggest that if parents develop increased receptiveness and skills to communicate with their children about these topics, they will increase communication. It is possible to improve the contents of parent-child conversations by raising awareness of parents and supporting them to challenge the social and cultural norms that restrict communication.^{24,25}
- ✦ **Mobilize community leaders.** Involving key community leaders, including religious leaders, can generate stronger community support. More evaluations—of community sensitization programs, especially concerning their impact on FP/RH service uptake by adolescents and youth or in changes in the opinions of community members with regard to AYRH—are needed.²⁶
- ✦ **Collaborate with community groups.** Community group participation is a promising, high-impact practice influencing individual behaviors and social norms on FP/RH.²⁷ It is important that community reflection and dialogue on FP/RH issues be led by individuals

from within the community as well as community groups that work with young people. As combined interventions report stronger results on contraceptive knowledge, awareness, and use, community engagement should be:

- Combined with other social and behavioral change strategies (e.g. engaging the media, interpersonal communication, or counseling)
- Combined with investments in improving service provision
- Embedded within larger programs that involve a range of interventions and stakeholders

✦ **Advocate for the development and implementation of supportive laws and policies.** Many governments have made strides in institutionalizing the ability of adolescents and youth to access FP/RH services. However, weak legal and policy frameworks or uneven implementation of these laws hinder young people's access to these services.²⁸ Advocacy is needed to encourage and support governments, implementing partners, and young people themselves to combat legal and policy barriers, including:

- Policies related to consent, age, and marital status
- The ability of young people to access the full range of FP methods
- Availability and implementation of Family Life Education
- Youth-friendly services; and supportive laws and policies for AYRH

Even when enabling laws and policies are in place, governments must be encouraged to exert political will, allocate adequate resources, build capacity to implement those enabling laws and policies, and establish accountability mechanisms.

✦ **Use media campaigns and other forms of social and behavior change communication.** "Edutainment" (entertainment-education programs) can encourage conversations about AYRH, although there have been very few evaluations of this approach's effect beyond knowledge-building and awareness-raising.²⁹ Media campaigns alone are insufficient to increase community support for AYRH. They should be implemented as part of a broader strategy that includes other social and norm change interventions, such as engaging men and boys and community mobilization.

IMPLEMENTATION CONSIDERATIONS

There are a variety of useful community engagement approaches. Typically, they involve engaging groups in assessing the identifying pressing AYRH problems in their own communities, prioritizing those problems, developing strategies to address those problems, implementing solutions, monitoring progress, and engaging in advocacy activities to promote AYRH. Like youth participation, community engagement is a process that both utilizes and fosters skills (and systems/structures) that are central to the development of a strong and vibrant civil society sector. This includes not only promoting awareness of young people's opportunities to access knowledge and services, but also engaging communities as partners in ensuring supportive AYRH policies and programs and holding duty-bearers accountable for addressing their needs.

PROGRAMMATIC EXAMPLE

The Gender Roles, Equality and Transformation (GREAT) Project, developed by Institute of Reproductive Health (IRH) at Georgetown University, Save the Children, and Pathfinder International, “aimed to promote gender-equitable attitudes and behaviors among adolescents (ages 10-19) and their communities with the goal of reducing gender-based violence and improving sexual and reproductive health outcomes in post-conflict communities in northern Uganda.” GREAT is comprised of a set of participatory activities to engage adolescents and adults in discussion and reflection about how to promote communities that are free of violence and gender inequality. GREAT activities included bringing communities together to assess, plan and act to improve adolescent wellbeing; a radio drama about young people and their families living in northern Uganda; an orientation for Village Health Teams to help them offer adolescent-friendly services; and a toolkit of reflective activities for community groups and school-based clubs. Evaluations results revealed that GREAT led to significant improvements in gender equitable attitudes and behaviors among exposed individuals compared to a combined control group.



EVIDENCE-INFORMED PRACTICES (EIPS)

PROMOTE GENDER EQUALITY

THE PRACTICE

Address the factors that limit girls and young women from having options, encourage boys to take risks, and create barriers to contraception and reproductive health care for both sexes.

Gender equality means that, regardless of sex, individuals should have equal ease of access to resources and opportunities, including civic, religious, political, and economic participation, and decision-making. The needs, aspirations, and behaviors of young men and women are equally valued. In terms of health, gender equality means that all young people should have access to quality FP/RH information and health care that is responsive to their specific needs, lifestage or experience, and cultural and social context.

WHY IT MATTERS

It is well-documented that gender inequality has a significant and negative impact on a range of reproductive health outcomes. Gender and age-related norms often limit girls' decision-making ability and options, while increasing their risk for gender-based violence, HIV, and other adverse reproductive health outcomes. Early/child/forced marriage represents one of the greatest violations of human rights, fundamentally compromising girls' futures and their health. Gender norms regarding masculinity may encourage young men and boys to take risks and discourage them from seeking health care, making them more vulnerable, for example, to HIV mortality.

Social and gender norms also support the notion that FP and RH are female spheres of responsibility—placing disproportionate burden on girls and young women for reproductive health action, while preventing boys and men from owning their own reproductive health.

SUGGESTED ACTIVITIES

- ✦ **Support programs that encourage young people to examine, discuss, and question gender norms and values.** Family Life Education programs that use curricula with an explicit focus on gender throughout are more effective than curricula that do not directly address gender norms. Creating a space for young people to engage with one another through structured and participatory educational sessions that systematically examine and question cultural norms about gender is an effective way to motivate young people to consider their behavior, responsibilities, relationships, and health.

- + Improve adolescent girls' access to school and support their retention.** Investments that enable girls to stay in school, especially secondary school, have wide, long-term benefits on the health and development of individuals, families, and communities. Evidence shows strong, positive linkages between girls' education and healthier behaviors.³⁰ Strategies that improve girl's participation in school include:

 - Challenging social norms that undermine girls and their education
 - Improving the quality and safety of the school environment
 - Providing economic incentives for sending girls to school and keeping them there
 - Promoting quality education, and linking health programs with schools.³¹

- + Engage men and boys to promote gender equity.** An increasing number of FP/RH programs address inequities and negative gender norms and behaviors by engaging men and boys through a participatory group education and dialogue, media campaigns, and digital health applications, as well as activities to mobilize the community at large. Other strategies may include working through multiple non-clinic, informal settings, such as mobile outreach, community health workers, drug shops and pharmacies, and social marketing. Integrated interventions that combine community group engagement, media-focused activities, interpersonal education, and health care targeted to men and boys yield promising results for gender equity.³²

- + Building young people's FP/RH-related capacities and assets.** Young people must be able to draw on their own knowledge, skills, and assets to take timely and desired action about their health.³³ Working with girls to build these resources is a cornerstone of gender-based programming, including women's empowerment and male involvement. Activities are often group-based and use participatory methodologies to create safe, shared spaces for youth to learn about FP/RH issues, develop life skills and form critical social networks. Many programs also strengthen young people's economic resources, by including financial literacy, vocational training and savings mechanisms. While attention to girls' and young women is essential, broader youth development and capacity building approaches, including those that work with both girls and boys together, can also support AYRH-related empowerment. For example, Positive Youth Development engages young people together with their families, communities, and/or government to build capacities, assets and competencies; foster healthy relationships; strengthen the environment; and transform systems benefits.³⁴

- + Eliminate gender-based violence (GBV) against girls and young women.** Violence and harmful practices, driven by underlying power and gender inequalities, affect girls and women throughout their lives and directly influence their reproductive health. GBV responses within FP/RH programs can include:

 - Strengthening health providers' capacity to screen for, and respond to, GBV—but only where services exist
 - Helping to build a services infrastructure for survivors, including health services, psycho-social support, and legal services
 - Working with communities to challenge and change harmful gender norms and practices and lower their tolerance to violence
 - Engaging girls and boys to influence their attitudes about gender and nonviolence. In some countries and contexts, specific harmful practices, such as female genital cutting/mutilation and child marriage should also be addressed

- + Eliminate child/early/forced marriage.** In several countries, marrying before age 18 is allowed by law. Even in countries where early marriage is illegal, laws are poorly enforced. In some areas, girls are expected to marry and have children during adolescence, often before

they are physically or mentally ready to do so. While establishment and enforcement of a legal minimum age of marriage is an important step to ending child marriage, it is just one part of a comprehensive child protection approach to ensuring the wellbeing of girls. Other necessary steps involve working with women and men,³⁵ community leaders, and other stakeholders to challenge and change social norms that encourage early marriage, engage in girls' empowerment activities, and disseminate information in all sectors of society about laws and policies that support the rights of children.

IMPLEMENTATION CONSIDERATIONS

FP/RH programming is most effective when it also addresses the social, gender, and economic factors that: limit girls and young women from having options, encourage boys to take risks, and create barriers to health care access for both sexes. In developing and implementing this kind of programming, careful thought should be given to several elements: the selection of the focus population of youth and their influencers; the assessment of their FP/RH situation and needs; an analysis of the gender and social factors that limit or facilitate their FP/RH action; the involvement of young people in program design, implementation and monitoring; the recruitment of program participants; the development of youth leadership; and the engagement and support of parents and communities.

PROGRAMMATIC EXAMPLE

Designed for young women, Promundo's Program M focuses on equitable gender roles, empowerment in interpersonal relationships, and reproductive health. Program M (named after *mulheres* and *mujeres*, the words for women in Portuguese and Spanish) was developed as a companion to Program H (named for *homens* and *hombres*, or men), which encourages critical reflection among young men about rigid gender norms. Building on the experiences of Program H, Program M was developed and field-tested in Brazil, Jamaica, Mexico, and Nicaragua. Program M methodology combines educational workshops with youth-led community campaigns that work to promote gender-equitable attitudes among young women and improve their agency in interpersonal relationships. Organizers can choose from some 33 validated Program M activities to customize the program for the needs of their communities. These activities address a variety of topics, ranging from gender identity to reproductive health, empowerment in interpersonal relationships, and motherhood and caregiving. Evaluation studies on Program M in Brazil and India, using items from the Gender Equitable Men (GEM) scale, found that women who participate in the program experience increased communication with partners about health, increased self-efficacy in interpersonal relationships, decreased drug use, and increased condom use by partners.

ENDNOTES

- 1 Rosenberg NE, Bhushan NL, Vansia D, et al. *Comparing Youth Friendly Health Services to the Standard of Care through “Girl Power-Malawi”: A Quasi-Experimental Cohort Study*. *J Acquir Immune Defic Syndr*. 2018.
- 2 Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher—Lancet Commission*. *Lancet*. 2018.
- 3 World Health Organization. *A standards-driven approach to improve the quality of health-care services for adolescents: Policy Brief*. Geneva: World Health Organization; 2015.
- 4 USAID et al. *The Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting and Reversible Contraception*. 2016.
- 5 Viner RM, Ozer EM, Denny S, et al. *Adolescence and the social determinants of health*. *Lancet* 2012; 379: 1641–52.
- 6 World Health Organization. *Health for the World’s Adolescents: A second chance in the second decade*. Geneva: World Health Organization; 2014. Accessed 4 May 2017. http://www.who.int/maternal_child_adolescent/documents/second-decade/en/.
- 7 West African Health Organization. *Orientation Guide for Developing National Strategies for Integrated Services for Adolescents and Young People in the ECOWAS Region*. 2015.
- 8 Haberland, Nicole A., Katharine J. McCarthy, and Martha Brady. *Insights and Evidence Gaps in Girl-Centered Programming: A Systematic Review*. GIRL Center Research Brief No. 3. New York: Population Council; 2018.
- 9 The Health Policy Project. *Resource Guide to Multi-Sectoral Coordination*. 2014. Accessed 13 August 2018. https://www.healthpolicyproject.com/pubs/272_MultisectoralCoordinationResourceGuide.pdf.
- 10 Ibid.
- 11 Ibid.
- 12 United Nations Secretary-General. *The global strategy for women’s, children’s and adolescent’s health (2016–2030): survive, thrive, transform*. 2015. Accessed 3 May 2017. <http://www.who.int/life-course/partners/globalstrategy/globalstrategyreport2016-2030-lowres.pdf?ua=1>.
- 13 Villa-Torres L, Svanemyr J. *Ensuring Youth’s Right to Participation and Promotion of Youth Leadership in the Development of Sexual and Reproductive Health Policies and Programs*. *Journal of Adolescent Health*. 2015; 56: S51eS57.
- 14 Patton, George C., et al. *Our future: A Lancet commission on adolescent health and wellbeing*. *The Lancet*. 2016; 387.10036: 2423-2478.
- 15 Ibid.
- 16 Katie Chau, Regina Benevides, and Ousseini Abdoulaye. *University Leadership for Change in Sexual and Reproductive Health in Niger: Project Report*. Washington, DC: Evidence to Action Project/ Pathfinder International; 2017.
- 17 World Health Organization. *A standards-driven approach to improve the quality of health-care services for adolescents: Policy Brief*. Geneva: World Health Organization; 2015.
- 18 Maticka-Tyndale E, Barnett JP. *Peer-led interventions to reduce HIV risk of youth: A review*. *Eval Program Plann* 2010; 33: 98–112.

- 19 Michelle J. Hindin et al. *Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low-and Middle-Income Countries: A Systematic Review of the Published and Gray Literature*. *Journal of Adolescent Health* 59, no. 3 (2016): S8-S15. <https://www.ncbi.nlm.nih.gov/pubmed/27562452>.
- 20 Ibid.
- 21 Chandra-Mouli V, Lane C, Wong S. *What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices*. *Global Health: Science and Practice*. 2015; 3(3): 333-40.
- 22 Keogh SC, Stillman M, Awusabo-Asare K, et al. *Challenges to implementing national comprehensive sexuality education curricula in low- and middle-income countries: Case studies of Ghana, Kenya, Peru, and Guatemala*. *PLoS One*. 2018;13(7):e0200513.
- 23 Biddlecom A, Awusabo-Asare K, Bankole A. *Role of parents in adolescent sexual activity and contraceptive use in four African countries*. *Int Perspect Sex Reprod Health* 2009;35:72e81.
- 24 Svanemyr, J. et al. *Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A Framework and Promising Approaches*. *Journal of Adolescent Health*. 2015; 56. S7-S14.
- 25 Denno, D. et al. *Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support*. *Journal of Adolescent Health*. 2015; S22.
- 26 Svanemyr, J. et al. *Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A Framework and Promising Approaches*. *Journal of Adolescent Health*. 2015; 56. S7-S14.
- 27 Kate Plourde et al. *Community Group Engagement: Changing Norms to Improve Sexual and Reproductive Health*. Washington, DC: USAID; 2016. Accessed 10 December 2016. www.fphighimpactpractices.org/sites/fphips/files/hip_cge_brief.pdf.
- 28 Harris, S, et al. *Youth Family Planning Policy Score Card*. April 2017. Accessed 3 August 2018. www.prb.org/Publications/Reports/2017/Global-Youth-Family-Planning-Index.aspx.
- 29 The Health Compass. *Gender Roles, Equality and Transformation (GREAT) Project*. Accessed 23 June 2018. <https://www.thehealthcompass.org/sbcc-spotlights/gender-roles-equality-and-transformation-great-project>.
- 30 High Impact Practices (HIPs) for Family Planning. *Educating Girls: Creating a foundation for positive sexual and reproductive health behaviors*. Washington, DC: USAID; 2014. Accessed 7 August 2018. <https://www.fphighimpactpractices.org/briefs/educating-girls/>.
- 32 Ibid.
- 32 Barker, G., C. Ricardo, and M. Nascimento. *Engaging Men and Boys in Changing Gender-Based Inequity in Health: Evidence from Programme Interventions*. Geneva: World Health Organization; 2007.
- 33 Population Council. *Building Girls' Protective Assets: A Collection of Tools for Program Design*. New York: Population Council; 2016.
- 34 Alvarado, G., Skinner, M., Plaut, D., Moss, C., Kapungu, C., and Reavley, N. *A Systematic Review of Positive Youth Development Programs in Low-and Middle-Income Countries*. Washington, DC: YouthPower Learning, Making Cents International; 2017.
- 35 Girls Not Brides (2017). *The Case for a Minimum Age of Marriage of 18*. Accessed 13 August 2018. <https://www.girlsnotbrides.org/wp-content/uploads/2017/12/Why-a-minimum-age-of-marriage-of-18.pdf>.

REFERENCES

- Alvarado, G., Skinner, M., Plaut, D., Moss, C., Kapungu, C., and Reavley, N. *A Systematic Review of Positive Youth Development Programs in Low-and Middle-Income Countries*. Washington, DC: YouthPower Learning, Making Cents International; 2017.
- Babalola S, Ramirez-Ferrero E, Muya A. *Survey on Sexual Attitudes and Behaviors among Tanzanian Youth: Baseline Assessment in Five Regions: Report of Findings*. Dar es Salaam: HealthScope Tanzania and the Johns Hopkins Center for Communication Programs; 2005.
- Barker, G., C. Ricardo, and M. Nascimento. *Engaging Men and Boys in Changing Gender-Based Inequity in Health: Evidence from Programme Interventions*. Geneva: World Health Organization; 2007.
- Biddlecom A, Awusabo-Asare K, Bankole A. *Role of parents in adolescent sexual activity and contraceptive use in four African countries*. *Int Perspect Sex Reprod Health* 2009.
- Centers for Disease Control and Prevention. *Effectiveness of Family Planning Methods*. 2014. Accessed 7 August 2018. <https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/pdf/Family-Planning-Methods-2014.pdf>.
- Centers for Disease Control and Prevention. *Principles of community engagement (2nd ed.)*. Atlanta (GA): CDC/ATSDR Committee on Community Engagement; 2011.
- Chandra-Mouli et al. *Programa Geração Biz, Mozambique: how did this adolescent health initiative grow from a pilot to a national programme, and what did it achieve?* *Reproductive Health*. 2015; 12:12.
- Chandra-Mouli V, Lane C, Wong S. *What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices*. *Global Health: Science and Practice*. 2015.
- Denno, D. et al. *Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support*. *Journal of Adolescent Health*. 2015.
- Every Woman, Every Child. *Technical Guidance for Prioritizing Adolescent Health*. 2017. Accessed 6 August 2018. https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_EWEC_Report_EN_WEB.pdf.
- Family Health International. *Youth Participation Guide: Assessment, Planning, and Implementation*. 2005. Accessed 14 August 2018. https://www.unicef.org/adolescence/cypguide/files/youth_participation_guide.pdf.
- Fikree FF, Abshiro WK, Mai MM, et al. *Strengthening Youth Friendly Health Services through Expanding Method Choice to include Long-Acting Reversible Contraceptives for Ethiopian Youth*. *Afr J Reprod Health*. 2017. 21[3]: 37-48.
- Girls Not Brides (2017). *The Case for a Minimum Age of Marriage of 18*. Accessed 13 August 2018. <https://www.girlsnotbrides.org/wp-content/uploads/2017/12/Why-a-minimum-age-of-marriage-of-18.pdf>.
- Haberland, Nicole A., Katharine J. McCarthy, and Martha Brady. *Insights and Evidence Gaps in Girl-Centered Programming: A Systematic Review*. GIRL Center Research Brief No. 3. New York: Population Council; 2018.
- Harris, S, et al. *Youth Family Planning Policy Score Card*. April 2017. Accessed 3 August 2018. www.prb.org/Publications/Reports/2017/Global-Youth-Family-Planning-Index.aspx
- High Impact Practices (HIPs) for Family Planning. *Community Group Engagement: Changing Norms to Improve Sexual and Reproductive Health*. Washington, DC: USAID; 2016.
- High Impact Practices (HIPs) for Family Planning. *Educating Girls: Creating a foundation for positive sexual and reproductive health behaviors*. Washington, DC: USAID; 2014. Accessed 7 August 2018. <https://www.fphighimpactpractices.org/briefs/educating-girls/>.

International Planned Parenthood Foundation. *Young People as Advocates: Your Action for Change Toolkit*. 2011.

Kate Plourde et al. *Community Group Engagement: Changing Norms to Improve Sexual and Reproductive Health*. Washington, DC: USAID; 2016. Accessed 10 December 2016. www.fphighimpactpractices.org/sites/fphips/files/hip_cge_brief.pdf

Katie Chau, Regina Benevides, and Ousseini Abdoulaye. *University Leadership for Change in Sexual and Reproductive Health in Niger: Project Report*. Washington, DC: Evidence to Action Project/Pathfinder International; 2017.

Keogh SC, Stillman M, Awusabo-Asare K, et al. *Challenges to implementing national comprehensive sexuality education curricula in low- and middle-income countries: Case studies of Ghana, Kenya, Peru, and Guatemala*. PLoS One. 2018.

Marston C, Hinton R, Kean S, Baral S, Ahuja A, Portela A. *Community participation for transformative action on women's, children's and adolescents' health*. 2016; 94(5):376–82.

Maticka-Tyndale E, Barnett JP. *Peer-led interventions to reduce HIV risk of youth: A review*. Eval Program Plann 2010.

McGinn, E. K., and H. J. Connor. *SEED assessment guide for family planning programming*. 2011.

Michelle J. Hindin et al. *Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low-and Middle-Income Countries: A Systematic Review of the Published and Gray Literature*. Journal of Adolescent Health 59, no. 3 (2016). <https://www.ncbi.nlm.nih.gov/pubmed/27562452>.

Patton, George C., et al. *Our future: A Lancet commission on adolescent health and wellbeing*. The Lancet. 2016.

Population Council. *Building Girls' Protective Assets: A Collection of Tools for Program Design*. New York: Population Council; 2016.

Population Council. *Girl-centered program design: a toolkit to develop, strengthen, and expand adolescent girls program*. Accessed 7 August 2018. http://www.ungei.org/files/2010PGY_AdolGirlToolkitComplete.pdf.

Simon C, Benevides R, Hainsworth G, Morgan G, and Chau K. *Thinking outside the separate space: A decision-making tool for designing youth-friendly services*. Washington, DC: Evidence to Action Project/Pathfinder International; 2015.

Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher—Lancet Commission*. Lancet. 2018;391

Svanemyr, J. et al. *Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A Framework and Promising Approaches*. Journal of Adolescent Health. 2015.

The Health Compass. *Gender Roles, Equality and Transformation (GREAT) Project*. Accessed 23 June 2018. <https://www.thehealthcompass.org/sbcc-spotlights/gender-roles-equality-and-transformation-great-project>.

The Health Policy Project. *Resource Guide to Multi-Sectoral Coordination*. 2014.

UNESCO. *Emerging Evidence, Lessons, and Practice in Comprehensive Sexuality Education: A Global Review*. Paris: UNESCO; 2015

UNFPA. *Adolescent Sexual and Reproductive Health*. Accessed 7 August 2018. <https://www.unfpa.org/resources/adolescent-sexual-and-reproductive-health>.

United Nations Secretary-General. *The global strategy for women's, children's and adolescent's health (2016–2030): survive, thrive, transform*. 2015. Accessed 3 May 2017. <http://www.who.int/life-course/partners/globalstrategy/globalstrategyreport2016-2030-lowres.pdf?ua=1>.

USAID et al. *The Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting and Reversible Contraception*. 2016.

Villa-Torres L, Svanemyr J. *Ensuring Youth's Right to Participation and Promotion of Youth Leadership in the Development of Sexual and Reproductive Health Policies and Programs*. *Journal of Adolescent Health*. 2015.

Viner RM, Ozer EM, Denny S, et al. *Adolescence and the social determinants of health*. *Lancet* 2012; 379: 1641–52.

West African Health Organization. *Orientation Guide for Developing National Strategies for Integrated Services for Adolescents and Young People in the ECOWAS Region*. 2015.

World Health Organization. *A standards-driven approach to improve the quality of health-care services for adolescents: Policy Brief*. Geneva: World Health Organization; 2015.

WHO. *Health for the World's Adolescents: A second chance in the second decade*. Geneva: World Health Organization; 2014. Accessed 4 May 2017. http://www.who.int/maternal_child_adolescent/documents/second-decade/en/.

WHO, Quality Assessment Guidebook. *A guide to assessing health services for adolescent clients*. Geneva, World Health Organization, 2009.

WHO/UNAIDS. *Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health-care services for adolescents*. Geneva: World Health Organization; 2015.