

# IMAP Statement

## on youth peer provision models to deliver sexual and reproductive health services to young people

The purpose of this Statement is to outline key components of the youth peer provision model, summarize existing evidence, and provide guidance to integrate this delivery approach into the existing sexual and reproductive health services offered by IPPF Member Associations.

### Introduction

This Statement has been prepared by the International Medical Advisory Panel (IMAP) and was approved in November 2016.

The International Planned Parenthood Federation (IPPF) embraces young people as partners, focuses on their lives and needs, and aims to ensure that youth are truly at the centre of all services, programmes and interventions. To support these efforts, this IMAP Statement explores the 'youth peer provision model' – **an innovative task sharing/task shifting approach to sexual and reproductive health service delivery to young people (aged 10–25)**, founded on the key principles of meaningful youth involvement, empowerment, and promotion of self-care and health literacy.

Task sharing/task shifting is a process in which specific clinical tasks are shared among different types of providers, ranging from a more professionalized health care worker to an existing lower level cadre, or shifted to a new cadre created to meet specific health care goals.<sup>1</sup>

### The purpose of this Statement

The purpose of this Statement is to outline key components of the youth peer provision model, summarize existing evidence, and provide guidance to integrate this delivery approach into the existing sexual and reproductive health services offered by IPPF Member Associations.

### Intended audience

This IMAP Statement is primarily intended for use by IPPF Member Associations and the IPPF Secretariat. It is also aimed at all sexual and reproductive health organizations, programmers in adolescent services and education (public and private), and the broader development community – including United Nations agencies – working to improve access to sexual and reproductive health for young people.

### Why do we need a youth peer provision model?

Barriers to accessing sexual and reproductive health services affect young people disproportionately. These barriers can be grouped into system and structural barriers, social and legal restrictions, and provider bias:<sup>2</sup>

- **System and structural barriers:** These barriers include weak infrastructure in health, communications and transport; inconvenient locations and opening hours; security in the community, city or country; affordability of care; and lack of trained health staff due to geographical, economic or political factors, as well as other barriers. According to the World Health Organization, deficiencies related to health staff include shortages of some categories of providers; aging of the workforce; skills-mix imbalances; challenges with attracting, retaining and acceptability of providers; and the inability of some health workers to meet and deliver quality services due, among other factors, to insufficient duration and scope of pre-service education or training, or failure of regulations to ensure that curricula reflect good practice and current evidence.<sup>3</sup>

By implementing a peer provider model or approach, IPPF responds to the changing needs and realities of young people and strives to provide the kind of services that young people would be likely to access and to which they would refer their peers, friends and family members.

- Social norms, public policies and legal restrictions:** These restrictions include stigmatization of youth sexuality and sexual pleasure; parental consent for minors; gender inequalities that prevent young girls from making decisions about their bodies, reproductive life and sexuality; compounding vulnerabilities faced by specific groups of young people; lack of recognition or visibility of young people in governmental strategies and plans to ensure access to health coverage; and other legal provisions preventing client confidentiality.
  - Provider bias:** In some facilities, health providers may refuse to provide sexual and reproductive health care to unmarried adolescents, or they may only provide care with parental permission because they disapprove of youth sexual activity. Young people, particularly young women, may be deterred from seeking the services they need, delay access to treatment or use unqualified providers if they feel they will be poorly treated or judged, or if they are concerned that their confidentiality and privacy will not be maintained.
- As a result, young people's sexual and reproductive health is compromised, as shown by the following data:<sup>4,5,6,7,8</sup>
- Unmet need for contraceptives:** In low- and lower-middle-income countries across Latin America and the Caribbean, Africa and Asia, only about one-third of married adolescent women who want to avoid pregnancy are using a modern contraceptive method. Overall, unmet need for contraception is even higher among unmarried sexually active adolescent women.
  - Unplanned and unwanted pregnancy:** In most Latin American and Caribbean countries, more than 50 per cent of recent births to women under 20 are unplanned. In a third of African countries the proportion is 40 per cent.
  - Access to safe abortion:** About 3.2 million of the estimated 22 million unsafe abortions that occurred in 2008 were among adolescents, and approximately one-third of all abortion-related deaths are among women younger than 25. Adolescents are more likely than older women to seek abortions from untrained providers, have less knowledge about their right to information and post-abortion care, and tend to take longer to recognize their pregnancies and consequently have later-term abortions.
  - Complications during delivery:** In developing countries, complications during pregnancy and childbirth are still the second leading killer of females aged 15–19, and the risks of dying rise with the proportion of young people in populations.
  - HIV/AIDS:** Young people aged 15–24 years account for an estimated 35 per cent of all new HIV infections in people over 15 years of age. According to UNAIDS, young women and adolescent girls acquire HIV an average of five to seven years earlier than young men, and in some countries HIV prevalence among young women and adolescent girls is as much as seven times that of their male counterparts.
  - Sexually transmitted infections:** Globally, sexually transmitted infections have significant consequences for sexual and reproductive health. An estimated 357 million new infections occur every year with one of four sexually transmitted infections: chlamydia, gonorrhoea, syphilis and trichomoniasis. The highest rates are among 20–24-year-olds, followed by 15–19-year-olds. A minority of sexually active adolescent women who have a sexually transmitted infection or symptoms of an infection seek care in a health facility.
  - Mental health:** The leading cause of death for adolescent girls aged 15–19 worldwide is suicide – poor reproductive and sexual health is among the most important contributors to poor mental health.<sup>9</sup>
- IPPF and other stakeholders have implemented a wide range of strategies and interventions to tackle these barriers, overcome poor health outcomes, and promote young people's sexual and reproductive rights. These include, but are not limited to, facility-based programmes (stand-alone clinics, separate spaces for youth-friendly services, mainstreamed youth-friendly services); outreach programmes (mobile services, community-based distribution and provision of care, pharmacies); and education initiatives (comprehensive sexuality education in and out of schools, peer education).
- However, more can be done to increase coverage, improve quality and respond to the diverse needs of different groups of young people. Innovative approaches are needed that put young people at the centre and that make use of available technology attractive to this population. By implementing a peer provider model or approach, IPPF responds to the changing needs and realities of young people and strives to provide the kind of services that young people would be likely to access and to which they would refer their peers, friends and family members.

## What is the youth peer provision model?

In IPPF, peer provision refers to a model in which **young people perform functions related to health care** to address the sexual and reproductive health needs and rights of **their peers**. The concept can be broken down as follows:

**Young people:** For statistical and programmatic purposes, IPPF defines young people as those between 10–25 years of age. Youth performing health care functions (youth peer providers) do not require a formal professional or para-professional certificate or tertiary education degree, but must be sensitized, trained, mentored and monitored in the context of the intervention.

**Perform health care functions:** Based on available evidence, trained young people implement tasks to prevent, diagnose, treat, maintain or restore physical or mental health, and to increase health literacy among their peers – that is, their capacity to obtain, process and understand basic health information;<sup>10</sup> explore their options; ask key questions about their choices; and actively participate in decisions concerning their care. The specific tasks recommended for youth peer providers are listed below.

**Peers:** Under this model, a peer is a young person, 10–25 years of age, who has specific sexual and reproductive health needs, and who expects to receive health care. While age is the main 'shared' characteristic between the youth peer providers and their peers, other similarities such as gender, sexual orientation, occupation, socio-economic background or health status can lead to better understanding, empathy and mutual support.

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## What tasks can be performed by youth peer providers?

While youth peer providers are not explicitly mentioned in the World Health Organization recommendations on task sharing/task shifting, it can be argued that they fit into the definition of community health workers (lay providers) in terms of their level of formal training to provide care.

A community health worker is an individual who performs functions related to health care delivery, was trained in some way in the context of the intervention, **but has received no formal professional or para-professional certificate or tertiary education degree.**<sup>11</sup>

This is important because while there is not a robust body of research focusing exclusively on youth peer provision programmes in the context of sexual and reproductive health, there is evidence to support the provision of sexual and reproductive health, HIV and maternal care services by community health workers.

Integrating community health workers into the health system is one of several proven "high impact practices in family planning" identified by a technical advisory group of international experts. When appropriately designed and implemented, community health worker programmes can increase use of contraception, particularly where unmet need is high, access is low and geographic or social barriers to use of services exist.<sup>12</sup>

In June 2009, a technical consultation held at the World Health Organization in Geneva concluded that community-based provision of progestogen-only injectable contraceptives by appropriately trained community health workers is safe, effective and acceptable.<sup>13</sup>

Using rapid diagnostic tests, lay providers who are trained can independently conduct safe and effective HIV testing services.<sup>14</sup>

The World Health Organization and IMAP recommendations state that **any** individual who has no formal professional or para-professional certificate or tertiary education degree, **but who has received competency training**, has the capacity to deliver the following services related to sexual and reproductive health:<sup>15,16,17,18,19</sup>

Based on available evidence, trained young people implement tasks to prevent, diagnose, treat, maintain or restore physical or mental health, and to increase health literacy among their peers.

### Integrated sexual and reproductive health services

#### Contraceptive counselling

Contraceptive services provision: condoms, emergency contraception, pills, injectables (a case study from Ethiopia recommends provision of Implanon by community health workers/health extension workers)<sup>20</sup>

#### Manual breast examination

#### Confirmation of pregnancy

Screening, counselling and referrals for sexual and gender-based violence

Sexuality and relationship counselling

### Maternal health services

#### Promotion of:

- care-seeking behaviour and antenatal care during pregnancy
- companionship during labour
- sleeping under insecticide-treated nets during pregnancy
- birth preparedness
- skilled care for childbirth
- adequate nutrition, and iron and folate supplements during pregnancy
- reproductive health and family planning
- HIV testing during pregnancy; exclusive breastfeeding; post-partum care

Administration of misoprostol to prevent post-partum haemorrhage

Provision of continuous support for women during labour in the presence of a skilled birth attendant

Distribution of oral supplements to pregnant women (under targeted monitoring and evaluation)

Initiation and maintenance of injectable contraceptives using a standard syringe

### Medical and surgical abortion and post-abortion care

#### Any trimester of pregnancy (recommended practices):

- pre-abortion/post-abortion counselling
- post-abortion contraception (short-term methods including injectables; implants only in the context of rigorous research)
- provision of information on safe abortion, including information on self-care

Note: self-management of abortion may be recommended for the following tasks:

- self-assessing eligibility (under rigorous research)
- managing mifepristone and misoprostol medication without direct supervision of a health care provider
- self-assessing completeness of the abortion process
- self-administering short-term methods including injectable contraception

#### First trimester of pregnancy (recommended under rigorous supervision):

- assessing eligibility for medical abortion
- administering the medications and managing the process and common side-effects independently
- assessing completion of the procedure and the need for further clinic-based follow-up
- management of uncomplicated incomplete abortion/miscarriage with misoprostol

Youth peer providers can be responsible for delivering services through a specific methodology (for example, support groups) or tool/device (for example, internet, mobile applications, hotlines).

### HIV and other services related to sexually transmitted infections

#### General:

- information and counselling on safer sex, sexuality, relationship and condom negotiation
- condom-related services

#### Voluntary testing and counselling:

- recognize HIV-related illnesses and refer patient for HIV testing
- offer HIV testing and counselling (including TB patients and those with a strong probability of TB)
- conduct pre- and post-test counselling
- HIV testing services using rapid diagnostic tests

#### Prevention of mother-to-child transmission:

- offer HIV counselling and testing to pregnant women
- carry out and interpret HIV test (rapid test or ELISA)
- counsel mother on interventions to reduce the risk of transmitting HIV to her infant
- advice and counsel on safer sex, partner and children testing
- educate on basic preventive measures for TB
- review strategies to decrease the risk of transmission at the time of delivery
- discuss where the prophylactic antiretroviral treatment will be stored until needed and how the woman will access the treatment at the correct time
- advise on contraception

#### Post-exposure prophylaxis:

- recognize exposure that could place health workers at risk of HIV infection
- manage self-limiting side-effects of antiretroviral drugs in post-exposure prophylaxis regimens
- carry out and interpret post-exposure HIV test
- provide counselling and support, and refer to formal psychological counselling as needed

#### Circumcision:

- provide counselling

#### Harm reduction:

- provide counselling on harm reduction for drug users

#### TB co-infection:

- identify an HIV-positive patient with symptoms such as chronic cough and/or chronic fever and/or weight loss as a probable TB patient and encourage/assist clinic visit

#### Antiretroviral treatment:

- prepare an individual to use antiretroviral treatment
- recognize/manage self-limiting drug side-effects and encourage/assist consultation or clinic visit when necessary
- monitor adherence to treatment

#### Sexually transmitted infections:

- syndromic management of sexually transmitted infections
- related counselling
- monitoring adherence to treatments

## How to involve youth peer providers in health care delivery

**Performance of functions related to health care in a peer's service pathway:** Based on an individual's health needs, a young client may be required to go through different stages or steps (for example, pre-counselling, procedure, post-counselling, follow-up visit, referral to other services). Youth peer providers may be responsible for delivering one or multiple interventions within that pathway.

**Performance of functions related to health care at a specific level in the continuum of care:** While some peer provision interventions establish a role for youth providers in primary or secondary care facilities, others focus on provision of services outside the formal health and social care system (the self-care level).

**Performing functions related to health care through a specific mechanism/tool:** Youth peer providers can be responsible for delivering services through a specific methodology (for example, support groups) or tool/device (for example, internet, mobile applications, hotlines).

Successful implementation of a youth peer provision model requires the existence of an enabling regulatory framework to support the implementation of health care functions by non-professional or para-professional staff.

Systematic reviews of peer provision models in the field of chronic diseases and mental health also provide relevant information about the benefits and impact of these interventions.

## Benefits of peer provision models – what do we know?

A review carried out by IPPF in 2015 on existing youth peer provision programmes taking place across the Federation and in other health organizations provided input about the perceived benefits of these interventions. Key informants expressed the view that the youth peer provision model had contributed to accelerated progress in achieving an increase in the delivery of sexual and reproductive health services;<sup>21</sup> addressing stigma in service provision; increasing the number of youth

volunteers empowered to participate in the sexual and reproductive health and rights movement; and improving health literacy and management of medications (for example, contraceptive methods, and treatments for HIV and sexually transmitted infections).<sup>22</sup> Systematic reviews of peer provision models in the field of chronic diseases<sup>23</sup> and mental health<sup>24</sup> also provide relevant information about the benefits and impact of these interventions.

Benefits for clients who receive peer provision services – chronic diseases	Benefits for clients who receive peer provision services – mental health
<p>Benefits:</p> <ul style="list-style-type: none"> <li>• increased confidence (self-efficacy)</li> <li>• increased perceived social support</li> <li>• increased positive mood</li> <li>• increased understanding of self-care</li> </ul> <p>Impact:</p> <ul style="list-style-type: none"> <li>• improved health behaviours</li> <li>• improved chronic disease control</li> <li>• decreased hospitalization and mortality</li> </ul>	<p>Benefits:</p> <ul style="list-style-type: none"> <li>• increased sense of independence</li> <li>• increased confidence</li> <li>• increased number of friends/networks</li> <li>• increased sense of self-acceptance and empathy</li> <li>• increased sense of hope</li> </ul> <p>Impact:</p> <ul style="list-style-type: none"> <li>• reduced hospital admission rates and longer community tenure</li> <li>• improved empowerment score</li> <li>• improved social functioning (social contact, integration)</li> <li>• improved employment opportunities as a result of a reduction in self-stigma</li> </ul>

## Recommendations for Member Associations and other organizations

IMAP recommends that Member Associations first pilot the youth peer provision model to prove viability in the specific context of the intervention, the acceptability of youth-led services by their peers and other health professionals, and to document lessons, costs and risk management practices before scaling up.

### KEY CONSIDERATIONS TO PLAN, IMPLEMENT AND MONITOR A PILOT INTERVENTION USING THE YOUTH PEER PROVISION MODEL

**Planning:** Before embarking on the implementation of a pilot intervention, it is necessary to 1) assess if the most pressing needs of the target population can be addressed by non-health professionals/para-professionals; 2) evaluate the potential acceptability of youth providers among their peers and other service providers; 3) assess the legal feasibility of the intervention regarding, in particular, national or local regulations on task sharing/shifting; 4) allocate human and financial resources to support the recruitment, training

and ongoing supervision of youth peer providers; 5) determine the profiles and roles of the peer providers; 6) assess the security of the intervention area and potential risks for youth peer providers; and 7) adapt internal policies and procedures – particularly those linked to client-provider confidentiality, child protection, the participation of youth peer providers in the health team, reporting processes, management of clients' payments, and safety and care of supplies (for example, if peer providers will be delivering contraceptive methods).

**Implementation:** Recruitment and training of youth peer providers takes place during this phase. Technical training should focus on developing the skills and competences required to perform the duties assigned and how and when to refer to higher level cadres of health workers. Technical training should be accompanied by sensitization activities and Member Associations should offer opportunities for pre-service training, in-service mentoring and refresher training. Once the implementation starts, youth peer providers

must record information about the sexual and reproductive health history of young clients (as other providers do). Ideally, Member Associations should not create parallel client records, but adapt existing client card registries for use by youth peer providers. Confidentiality of client records must be assured. Finally, during the implementation phase, it is important to develop strategies to track and address turnover of youth peer providers, as this could affect the impact and continuity of the intervention.

**Quality improvement, monitoring and evaluation:**

Self-assessment processes, supportive supervision, mentoring and client feedback can be used regularly to monitor and improve the quality of care provided by youth peer providers and to listen to and address their needs. In addition, Member Associations should have in place systems to monitor and analyze client and service data, involving the youth peer providers in the analysis process. Finally, Member Associations should document lessons learned and success stories and identify areas that require further operational research.

**Tip for programming:** Engage young people as partners in the planning, implementation, and monitoring and evaluation phases.

**Strengthening and scaling up:** If a Member Association concludes during the pilot phase that the intervention is effective, efficient, relevant and sustainable in its context, and that there is a positive impact on health outcomes and empowerment, the youth peer provision model can be strengthened and scaled up by expanding the coverage and the package of services offered, reaching new under-served groups of young people, or by trying new mechanisms or settings to provide services – for example, online services (if technology allows) or home care.

**ADVOCACY CONSIDERATIONS**

Successful implementation of a youth peer provision model requires the existence of an enabling regulatory framework to support the implementation of health care functions by non-professional or para-professional staff. In addition, peer provision is underpinned by recognizing young people as sexual beings, who have the right to the highest standard of health and the capacity to make autonomous decisions. Advocacy by Member Associations should focus on changing policies that create barriers for young people to access comprehensive sexual and reproductive health services and on modifying regulations that are not based on the latest evidence and recommendations by authoritative sources in relation to the role of health providers.

**Recommended resources**

- The *Youth Peer Provider Program Replication Manual* by Planned Parenthood Global, offers guidance to develop a peer provision training programme.
- World Health Organization (2015) *Health Worker Roles in Providing Safe Abortion Care and Post-abortion Contraception*.
- World Health Organization (2012) *Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions Through Task Shifting*.
- World Health Organization (2008) *Task Shifting: Rational Redistribution of Tasks Among Health Workforce Teams: Global Recommendations and Guidelines*.

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## WHO WE ARE

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.



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