MSI
REPRODUCTIVE CHOICES

2026



A FRAMEWORK FOR ACTION

ADVANCING ADOLESCENT ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Contents

01 The Case for Action

02 MSI's Adolescent Clients

03 Our Vision and Guiding Principles

04 The Advancing Adolescent Access Framework

05 Measuring Progress

06 The AAA Playbook: Actions and Recommendations by Domain

Introduction:

Advancing Adolescent Access, Choice and Agency

Young people have the right to make decisions about their bodies, relationships and futures. Yet too many are denied the information, choices, healthcare and support that they need to do so.

MSI's Advancing Adolescent Access (AAA) Framework sets out how we can work alongside adolescents to change this, strengthening their agency, challenging the norms and barriers that hold them back, and building environments in which every young person can exercise their sexual and reproductive health and rights (SRHR) and shape the future they choose.

Five interconnected domains of the Framework turn this ambition into action: Commit, Partner, Engage, Deliver and Enable. Together, they place young people's voices, choices and leadership at the heart of MSI.





THE CASE FOR ACTION

A Generation of Possibility, Creativity and Leadership

Adolescence is a time of possibility, discovery and creativity. It is a period when young people begin to shape their identities, pursue their ambitions, build relationships and imagine the futures they want for themselves. When adolescents have access to accurate information, quality healthcare and the freedom to make informed choices about their bodies and lives, they are better able to embrace opportunities, fulfil their potential and build futures on their own terms.

Young people are not simply beneficiaries of change. They are innovators, advocates, leaders and decision-makers, bringing valuable knowledge, energy and perspectives to their families, communities and societies. When adolescents are trusted, listened to and meaningfully involved in the decisions that affect them, they can challenge harmful norms, improve services and help create more inclusive and equitable communities.

The scale of this opportunity is unprecedented. The world is home to 1.2 billion adolescents aged 10–19, representing the largest cohort of adolescents in history. This generation represents an extraordinary source of talent, ideas and leadership. Investing now in adolescents' health, education, rights and opportunities can help unlock a demographic dividend, strengthen economies and enable young people to shape healthier, fairer and more prosperous societies.





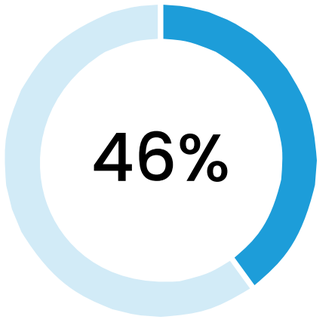
The Challenge for Adolescent SRHR

Adolescence is a critical time for a young person's SRHR, which is essential for adolescent dignity and well-being.

12M teenage girls give birth each year, globally.[1]

Although we've seen a decline in teenage pregnancy in all regions, sub-Saharan Africa has the highest rates at 97.9 births per 1000 women.[1]

Unmet demand for contraception is about three times as high among adolescents aged 15-19 (25%) as it is among all women (8%).[2]



of adolescents' unintended pregnancies end in abortion, with many compelled to seek out unsafe ways to end their pregnancy.[2]

Complications during pregnancy and childbirth are among the leading causes of death for girls aged 15-19.[1]

Gender inequalities and sexual and gender-based violence (SGBV) manifest in adolescence, including sexual abuse, early marriage, and unmet contraceptive needs.

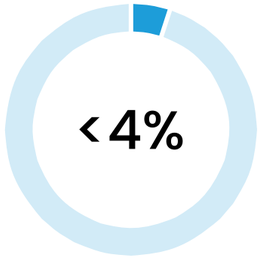
1. **WHO (2024)** Adolescent Pregnancy
2. **Guttmacher Institute:** Adding It Up 2024: Investing in Sexual and Reproductive Health in Low- and Middle-Income Countries

Adolescent Pregnancy has Lifelong Impacts

Up to
6M

pregnant and parenting girls aged 10-19 in sub-Saharan Africa are out of school.[3]

Adolescents girls aged 15-19 in South Asia are three times more likely than boys to not be in school, employment or training



Niger

Less than 4%
of girls will finish secondary school.[4]

Zambia

8,000
girls dropped out in 2025 due to pregnancy.[5]



The stakes compound over time...

1 additional year of education can raise future earnings by **10 to 20%.**[6]

3. **UNICEF:** Supporting the Education and Health of Young Mothers in Africa
4. **UNESCO Data Brief 2025-2028** Data Brief 2025-28 Niger
5. Zambia Education Statistics Bulletin 2025 (Chapter 4)
6. **Deliver for Good Network:** The Investment Case for Girls & Women. No date.
7. **United Nations Children's Fund, UN Women and Plan International, Girl Goals**: What has changed for girls? Adolescent girls' rights over 30 years, UNICEF, New York, 2025.

Adolescents Face Multi-Layered Barriers to Accessing Services

Individual	Limited knowledge on SRHR and entitlements, plus fear and misinformation.
Relationships	Power dynamics with partners, pressure around sex, lack of support from parents or trusted adults.
Community	Social and gender norms that stigmatise sexuality, especially if unmarried.
Services	Concerns around confidentiality or judgement, limited method choice, cost, distance and inconvenient service hours.
Systems	Restrictive laws or unclear policies on consent, contraception, abortion and comprehensive sexuality education.



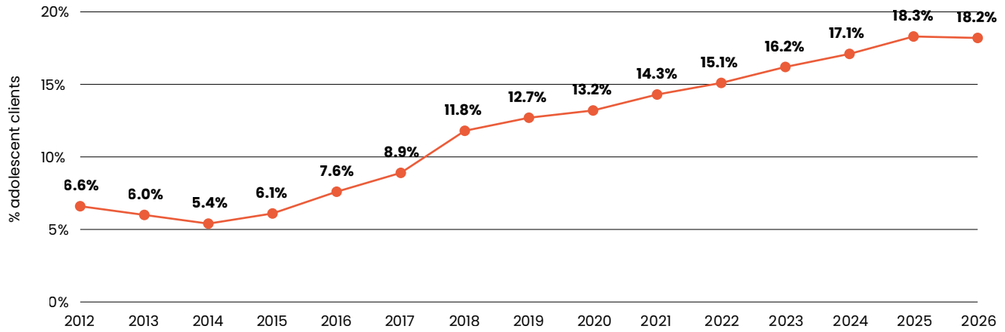
MSI'S ADOLESCENT CLIENTS



MSI's Position in the Landscape of Adolescent SRHR

MSI supports millions of adolescents each year. Our adolescent reach is three times higher than national benchmarks for adolescent contraceptive demand, with particularly high levels in DRC, Sierra Leone and Mali, where over a quarter of our clients are aged 15-19.

When we launched our tailored adolescent strategy in 2018, 6% of our clients were adolescents (under 20 years old). We've tripled that to 18% in 2025 through our mobile outreach and public sector support approaches. Our 'MSI Ladies' – local midwives and nurses who provide contraceptive services and advice to women and girls in their own homes – are particularly successful in reaching young people. In 2025, 32% of MSI Ladies' clients were adolescents.



Proportion of MSI clients who are adolescents (15-19) in our last-mile services

In 2025, MSI Supported 3.4 Million Adolescents with Reproductive Choice

With access to MSI's sexual and reproductive healthcare services in 2025, we estimate that 620,000 adolescents were able to remain in school.

Watch this short video to hear directly from Aisha, one of MSI's clients in Senegal, on how she was able to choose her own future.

"At school we often see girls who fall pregnant and usually don't come back. My service with MSI really helped me, because I could have stopped my studies. I am now in my final class. It's thanks to MSI that I've been able to finish my studies."

Aisha, MSI client in Senegal



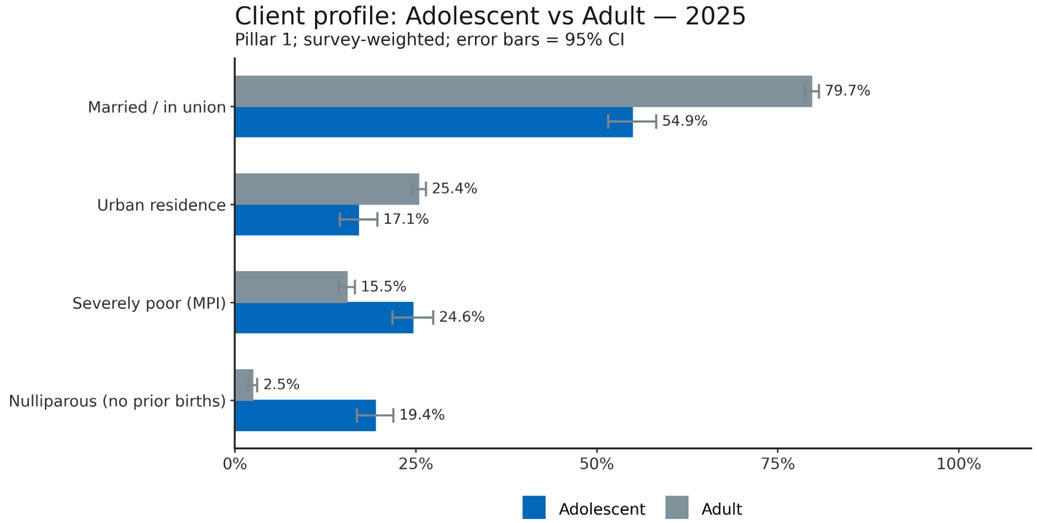
1. Read MSI's 2025 Impact Brief for more insights into 50 years of impact

The Adolescents We Reach

The majority of our adolescent clients age 15-19 are married (55%) but a significant proportion are unmarried (45%). While our adolescent clients are more likely to have had no prior births compared to adult clients (20% vs 3%), 80% already have at least one child.

Compared to our adult client base, adolescents are more likely to be economically vulnerable and have had less prior engagement with SRH services.

In 2025, 88% of adolescents we served were first-time visitors to MSI, compared to 75% of adults, and 72% were not using a modern method prior to their visit (vs 52% of adults). Adolescents were also more likely to want a long-acting method of contraception prior to their visit than adult clients.



OUR VISION AND GUIDING PRINCIPLES





MSI's Vision for Adolescent Access

MSI's adolescent programming aims to support young people to make informed, voluntary choices about their SRHR.

We aim to:

- Increase adolescent knowledge, confidence and self-efficacy to make informed choices and seek services when needed
- Create enabling environments and shift restrictive norms through supportive partners, families, peers and communities
- Expand access to adolescent-responsive services that are high-quality, confidential and non-judgemental
- Strengthen policies, systems, funding and accountability for equitable, adolescent-responsive service delivery

So that adolescents can:

- Choose when and if they want to delay or space pregnancies by using modern contraception
- Access abortion and post-abortion care within legal and policy frameworks
- Protect themselves from HPV and related cancers, through HPV vaccination and other preventative health services

Life Course Lens

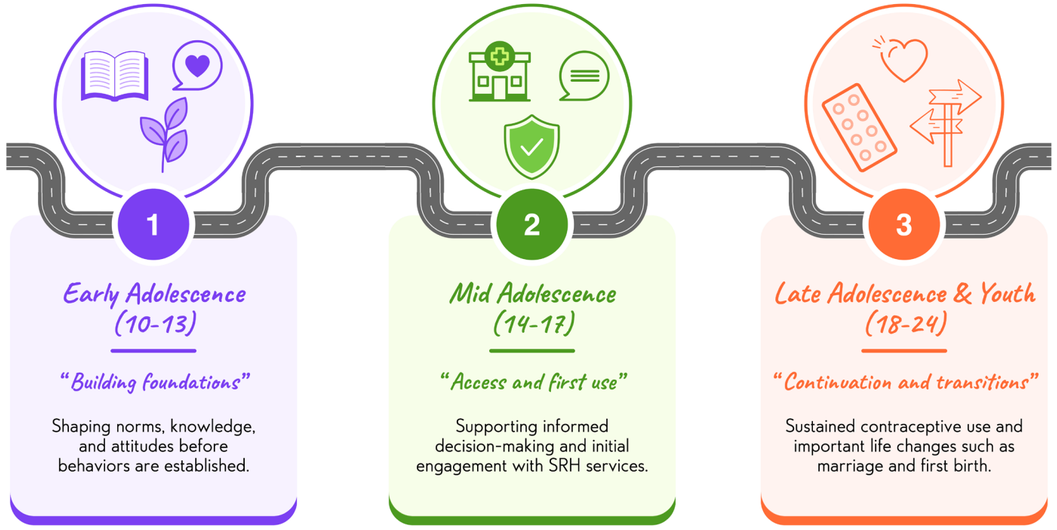
A life course lens helps ensure adolescent SRHR programmes respond to evolving needs at each stage of development.

Early adolescence (10-13) focuses on building foundations – shaping norms, knowledge, and attitudes before behaviours are established.

Mid adolescence (14-17) centres on access and first use, supporting informed decision-making and initial engagement with services.

Late adolescence and youth (18-24) emphasises continuation and transitions, including sustained contraceptive use and important life changes such as marriage and first birth.

MSI tailors approaches to these stages to better meet adolescents where they are, with a particular focus on those in mid and late adolescence as young clients begin engaging with MSI's services. In addition to age, MSI strives to understand the needs of specific adolescent segments, including married adolescents, adolescents living with a disability, survivors of gender-based violence, sexual and gender minorities, and those living in conflict or crisis settings.



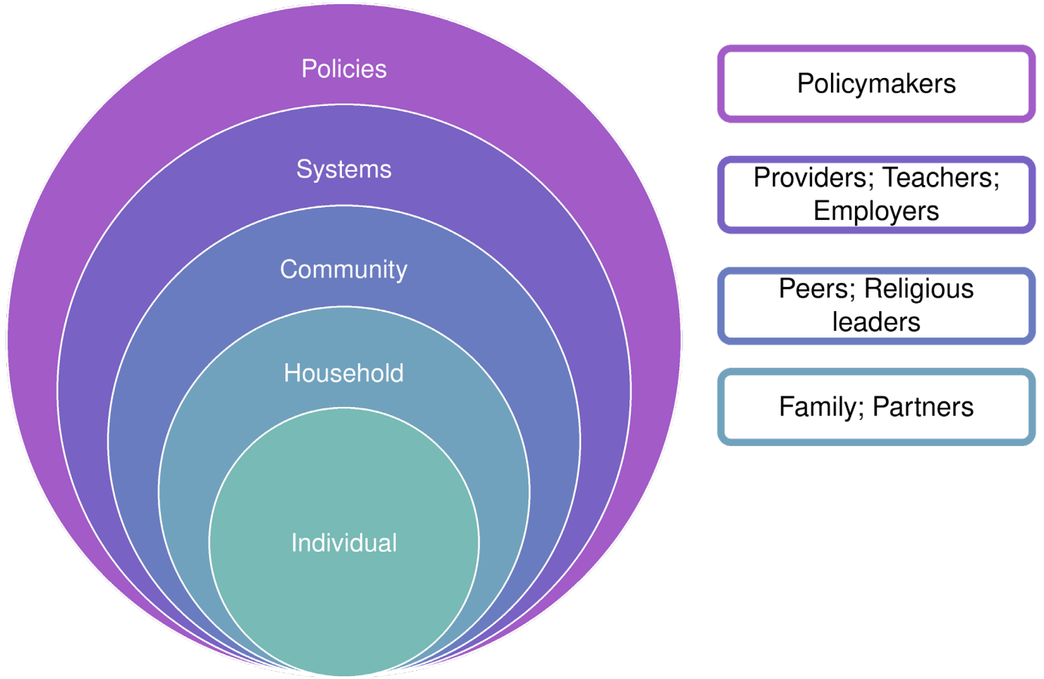
Holistic Approach

Adolescents’ SRHR is shaped by the people, systems and environments around them, not just by their own individual knowledge and choices.

We take a holistic approach, grounded in the social ecological model, that considers the interconnected influences of families, peers, schools, communities, health systems, and wider social and economic environments.

Our programmes aim to respond to the broader realities of adolescents' lives, including education, relationships, livelihoods, mental wellbeing, gender norms and access to quality healthcare.

By working across sectors and engaging the key influencers in adolescents’ lives, we create an enabling environment that supports informed choice and healthy futures.



Safeguarding

Adolescents often face higher risks of exploitation, abuse, and harmful practices. They may also face heightened vulnerability when accessing SRHR information and services, including power imbalances with providers, parents, teachers and other adults. MSI is committed to ensuring that all adolescents are treated with dignity, confidentiality, and respect for their rights, in line with ***MSI's Child Safeguarding Policy*** **and** safeguarding principles.

Safeguarding is a shared responsibility and should shape every interaction adolescents have with MSI-supported services and programmes. Country programmes integrate safeguarding into training, supervision, implementation and monitoring of adolescent programmes across all channels. Additional considerations may be needed with digital interventions, including concerns about sensitive content and data privacy.

Child safeguarding is a core component of MSI's safeguarding matrix, which helps teams identify and mitigate risks to adolescents through measures such as staff training, safe programming, clear reporting mechanisms and ongoing risk assessment.



Leave No One Behind

MSI's commitment to leaving no one behind means intentionally designing adolescent programmes to reach those who are most likely to be excluded from SRHR information and services. This includes adolescents living in rural and underserved areas, those affected by poverty, disability, humanitarian crises, HIV and other forms of marginalisation.

Across the framework, we apply an equity lens to understand who is being missed and adapt our approaches accordingly. This may mean bringing outreach services to remote communities, conducting assessments on inclusivity to strengthen accessibility, or testing innovative approaches that meet the unique needs of adolescents living with a disability.

We apply a gender transformative approach across all aspects of our work, ensuring we engage girls and boys, women and men, and intentionally address the gender-based drivers of inequitable access to SRHR.

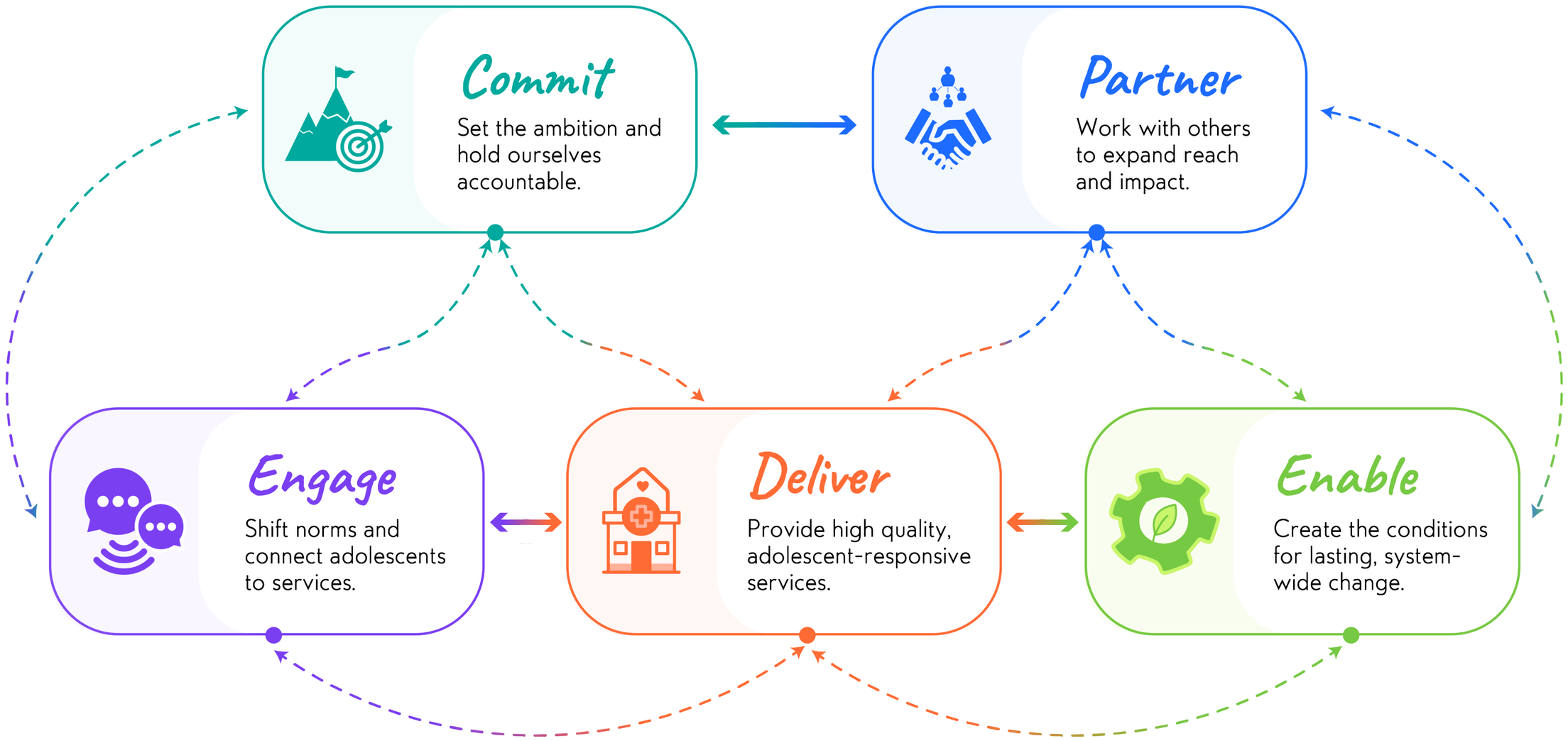
While MSI's experience continues to evolve, this principle challenges us to consistently ask who is not being reached and what more we can do to ensure all adolescents can access SRHR.



AAA: THE ADVANCING ADOLESCENT ACCESS FRAMEWORK



Advancing Adolescent Access (AAA) Framework



About the AAA Framework

This framework brings together five interconnected domains that together support adolescent-responsive programming at MSI: Commit, Partner, Engage, Deliver and Enable. These domains are not intended to operate in isolation or in a linear sequence. Progress in one area strengthens and reinforces the others.

For example, stronger partnerships improve communication and referral pathways, while enabling policies support better service delivery and more effective community engagement. Together, they create a dynamic and mutually reinforcing ecosystem that supports adolescent access, choice and agency in ways that an intervention focused on one domain alone cannot accomplish.

The actions and recommendations within this framework reflect MSI's existing practices that have helped us to reach and serve adolescents. They also incorporate approaches informed by evidence, research and best practice that may be underutilized. Some are areas where MSI already has strong experience and proven models, while others represent opportunities to deepen, adapt or expand how we support adolescents in the future.

Recommendations are based on broad best practice and may need to be contextualized for specific country contexts.

The bibliography at the end of this framework lists key articles reviewed as part of the development process.

COMMIT	Set the ambition and hold ourselves accountable
PARTNER	Work with others to expand reach and impact
ENGAGE	Shift norms and connect adolescents to services
DELIVER	Provide high-quality, adolescent-responsive services
ENABLE	Create the conditions for lasting, system-wide change

MEASURING PROGRESS



Key Performance Indicators (KPIs)

%

Proportion of contraception and abortion/post-abortion care visits by clients under 20 years old, by age group (10-14, 15-19 years) and sex.

#

Number of contraception and abortion/post-abortion care visits by clients under 20 years old, by age group (10-14, 15-19 years) and sex.

#

Number of countries where MSI's adolescent reach meets or exceeds the national contraceptive demand coming from adolescents.

Source: MSI routine service data
Target: In line with or above estimated adolescent unmet need/demand for contraception (source: DHS)

Additional KPIs

DOMAIN	INDICATOR	SOURCE
COMMIT	Number of countries with explicit adolescent goals in their business plan	Project documentation
PARTNER	Formal roles for adolescents and youth in country feedback mechanisms and/or advisory boards	Country documentation
	Number of formal partnerships established with government and non-government partners to support adolescent programming	Country documentation
ENGAGE	Percentage of adolescent clients that agree that people like them are stigmatised if their community knows they use contraception	Client exit interviews (CEI)
	Percentage of respondents who agree adolescents should have access to contraception without parental/partner consent	KAP survey; Programme
	Percentage of community-based mobilisers trained who demonstrate increased knowledge and skills on adolescent-responsive services	Pre and post assessment data
	Number and Percentage of contact centre conversations with adolescents	C3/Contact Centre Dashboard
DELIVER	Percentage of adolescent clients who report that they were treated with respect	CEI/routine client feedback
	Percentage of adolescent clients who report receiving counselling in line with the Method Information Index (MII+) standards	CEI/routine client feedback
	Percentage of providers trained who demonstrated increased knowledge and skills on adolescent-responsive services	Pre and post assessment data
ENABLE	Number changes to policy that MSI contributed to (legislation, financing, regulatory) that increase access to adolescent SRHR	Project tracking

Useful Population Level Indicators

AREA	INDICATOR
BEHAVIOURAL	Proportion of female adolescents (10-19 years) who were aware of menstruation before menarche, by age group (10-14, 15-19 years)
BEHAVIOURAL	Proportion of female adolescents (15-19 years) who make their own informed decisions regarding sexual relations, contraceptive use and reproductive healthcare
BEHAVIOURAL	Proportion of adolescents (15-19 years) who had their first sexual intercourse before 15 years of age, by sex
BEHAVIOURAL	Proportion of adolescents (10-19 years) who used a contraceptive (modern method) at last sexual intercourse, by method used, age group (10-14, 15-19 years) and sex
BEHAVIOURAL	Proportion of adolescents (10-19 years) who used a condom at last sexual intercourse, by age group (10-14, 15-19 years) and sex
BEHAVIOURAL	Proportion of adolescents (10-19 years) who have their need for contraception satisfied with modern methods, by age group (10-14, 15-19 years) and sex
HEALTH OUTCOMES	Adolescent (10-19 years) birth rate, by age group (10-14, 15-19 years)
HEALTH OUTCOMES	Proportion of adolescents (10-19 years) who experienced sexual or physical violence during the past 12 months, by perpetrator (parents/caregivers, teachers, other adults, intimate partners, peers), age group (10-14, 15-19 years) and sex
HEALTH OUTCOMES	Number of new cases of STIs among adolescents (10-19 years), by age group (10-14, 15-19 years) and sex
SYSTEMS PERFORMANCE	Proportion of 15-year-old adolescents covered by human papillomavirus (HPV) vaccine (last dose in schedule), by sex
SYSTEMS PERFORMANCE	Proportion of schools that offered life skills-based HIV and sexuality education during the previous academic year
POLICIES AND LAWS	Absence of legal age limit for married and unmarried adolescents (10-19 years) to provide consent, without spousal/parental/legal guardian consent, for specified adolescent health services, by marital status and type of service.

Common data sources: nationally representative household surveys, such as DHS, MICS; WHO Global Health Observatory

Research and Learning Strategy

MSI's 2030 **Research and Learning Strategy** aims to address key evidence gaps in the SRHR sector, with a focus on our core services (contraception and abortion). Adolescent-specific questions are embedded across our research and learning priorities.

For example:

- What service delivery models and approaches work to achieve equitable and inclusive reproductive healthcare that meets the needs of adolescents, youth, and persons living with disabilities?
- What strategies work to deliver SRHR information and services that are responsive to adolescent needs and how might they be adapted to effectively consider the needs and preferences of adolescents in different contexts?
- What are the impacts of interventions with community influencers and gatekeepers for adolescent SRH decisions on improving adolescents' access to SRH services?
- How does the implementation of mobile outreach services contribute to meeting the demand for contraception, particularly for underserved populations such as those living in poverty, adolescents, and individuals affected by displacement?
- How effective are school-based SRHR education programmes in improving adolescents' knowledge and utilisation of SRHR information and services?





THE AAA PLAYBOOK: ACTIONS AND RECOMMENDATIONS BY DOMAIN



Commit

Set the ambition and hold ourselves accountable

COMMIT sets adolescent SRHR as an explicit organisational priority.

This domain is about leadership, ambition and accountability: making sure adolescent access is visible in strategy, translated into country plans, and tracked through clear performance metrics. Sustained progress requires more than good practice; it needs shared goals, leaders to own it, and regular use of data to see what is working and where to course-correct.

Recommended actions:

1. Set the ambition
2. Track and show progress

1. Set the Ambition

WHY?

Setting a clear goal makes adolescent access to SRHR visible, intentional and non-negotiable. It signals that this is not a side priority, but core to achieving MSI's 2030 vision.

HOW?

We set and reinforce ambition through strategy, planning and leadership. In practice, this means:

- **Embed targets in strategy** at the global level.
- **Translate into country plans** through business planning and contextualised national-level targets.
- **Champion through leadership** with consistent messaging from the Executive Team and country Senior Management Teams.
- **Align around equity** by linking adolescent access to MSI's core strategy pillar of leaving no one behind.

IN PRACTICE

MSI's global 2021-2030 strategy includes an explicit goal to expand access to adolescents under our 'Leave No One Behind' Pillar:

"Ensure at least 50% of our clients are under 24 years old; increase from 15-20% the proportion of clients who are under 20 years old."



2. Track and Show Progress

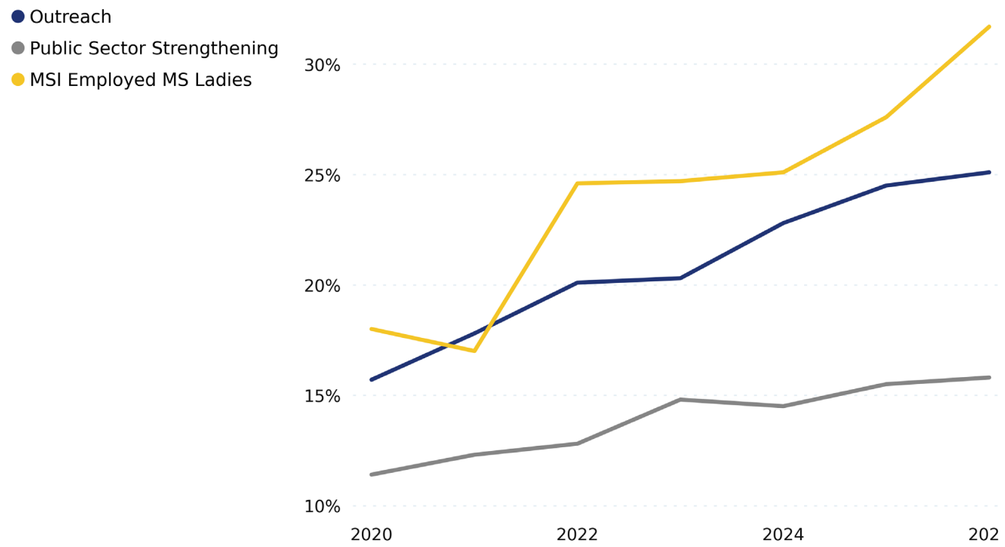
WHY?

What gets measured gets done. Tracking progress ensures our ambition leads to real change. It helps us to see where adolescents are being reached and where gaps remain. It also creates accountability, keeping this priority visible to leadership and country teams.

HOW?

In practice, this means:

- **Define clear KPIs** on adolescent reach and access.
- **Disaggregate adolescent data** by age group (10-14, 15-19 years) and sex.
- **Track and report** regularly across all country programmes.
- **Review performance** at global, regional and country levels.
- **Account for variations** based on delivery channel attributes (e.g. outreach vs. public sector support sites).
- **Ensure MSI's ethics guidance is followed** in all research, monitoring, and evaluation processes involving minors.
- **Conduct periodic mystery client surveys** with adolescents to explore aspects of clinical quality and client-provider interaction.
- **Use data to adapt** strategies and improve results over time.
- **Appoint a Senior Management Team staff member** in each country to review adolescent KPIs and hold colleagues across all relevant departments to account for adolescent performance.



IN PRACTICE

MSI uses data visualisation tools to track and monitor the proportion of adolescents served at MSI sites by country, region and channel. Since 2016, MSI has steadily increased the proportion of adolescent clients under 20 years old across all delivery channels.



Partner

Work with others to expand reach and impact.

PARTNER recognises that adolescent SRHR cannot be advanced by MSI alone. Young people's lives are shaped by education, families, communities, health systems and wider social structures.

This domain focuses on meaningful adolescent and youth engagement (MAYE) and practical partnerships across sectors. Partnerships help MSI stay focused on our reproductive healthcare expertise while expanding reach, trust, referrals and sustainable access.

Recommended actions:

1. Engage youth as partners
2. Unlock multi-sector impact

1. Engage Youth as Partners

WHY?

Adolescents should have a real say in the programmes designed for them. When young people are genuinely involved, programmes are more relevant, more trusted, and more likely to be used. This principle is reflected in MSI's endorsement of the Global Consensus Statement on Meaningful Adolescent and Youth Engagement (MAYE).

HOW?

We engage adolescents as partners throughout the process, not just as participants. In practice, this means:

- **Allow enough time and budget to co-design inclusively** with a diverse range of young people, including those most impacted by inequality and discrimination (e.g. adolescents living with a disability, sexual and gender minority youth).
- **Create formal roles** for adolescents and youth through representation on boards and project steering committees.
- **Budget for participation** across the full project lifecycle, compensating adolescents and youth for their time and factoring in natural attrition as young people transition over time.
- **Invest in support and capacity building,** including dedicated staff time to mentor and enable meaningful engagement.
- **Put clear structures in place,** such as selection criteria, consent processes, and codes of conduct to ensure safe, respectful participation, especially for youth under 18 years old.

KEY RESOURCE: International Youth Alliance for Family Planning Resources



IN PRACTICE

Under the Youth for Health project, MSI co-created a MAYE Charter that outlines five core principles to inform the design and implementation of youth and adolescent programming:

1. Continued collaboration
2. Encouraging ownership
3. Appreciation and respect for diversity
4. Transparent and accountable
5. Safe and ethical

2. Unlock Multi-Sector Impact

WHY?

The most powerful gains in adolescent wellbeing come from coordinated, multi-sectoral action. Evidence shows that when sectors like health and education work together, outcomes are stronger and more sustained. Partnering across sectors allows MSI to stay focused on its healthcare expertise while contributing to more holistic support for adolescents and youth. It also strengthens two-way referral networks, helping adolescents access a broader range of services to fulfil their needs. Strengthening partnerships with actors working on education, school-retention, child marriage and economic empowerment also influence long-term SRHR outcomes for adolescents.

HOW?

We build practical two-way partnerships that support coordination, learning and shared results. In practice, this means:

- **Engage with relevant government ministries and departments** to align priorities and enable coordinated action.
- **Partner with comprehensive sexuality education (CSE)** experts for curriculum development and delivery, focusing MSI's role on our core service delivery strengths.
- **Equip education stakeholders** (e.g. school nurses, teachers) as trusted referral agents to MSI-supported services.
- **Strengthen referrals** so adolescents can move easily between MSI and partner services.
- **Establish feedback and learning loops** with partners, ensuring input is acted on and improving how services connect over time.



IN PRACTICE

In Senegal, MSI partnered with the Ministry of Education and other civil society actors to co-design the "Zero Pregnancies in Schools" intervention aimed at reducing early pregnancies.

MSI Senegal organised a wide variety of activities aimed at addressing stigma around adolescent SRH, from school health talks to sports tournaments, ensuring involvement of all reference groups (including boys) who were influencing social norms. Teacher, pupil and parent champions were also trained in interpersonal communication and advocacy techniques to engage their peers and individual gatekeepers in dialogue. Furthermore, the project integrated menstrual hygiene management by providing sanitary products in schools. The entire intervention is underpinned by a referral system to MSI-supported public health facilities for contraceptive services.
The pilot evaluation showed an improvement in knowledge, behaviour and practices relating to reproductive health among 15–19-year-old pupils in the six intervention schools.



Engage

Shift norms and connect adolescents to services.

ENGAGE focuses on social and behaviour change (SBC): understanding adolescents, shifting norms and connecting young people to services.

This domain looks at how MSI uses data and audience segmentation to create tailored messaging and referrals that support adolescent access to services. Adolescents do not make decisions in isolation: their choices are shaped by peers, partners, families, communities, online information, and wider gender and social norms.

Recommended actions:

1. Understand audiences and norms
2. Use data-driven segmentation
3. Meet adolescents where they are with tailored messaging
4. Use menstrual health as an entry point
5. Leverage key life events
6. Integrate gender norms with a life course lens
7. Activate supportive influencers
8. Mobilise high-impact referral networks

1. Understand Audiences and Norms

WHY?

Effective SBC starts with understanding both individual decision-making and social and gender norms. Adolescents' knowledge, attitudes and choices are influenced not only by what they believe, but by expectations from partners, families and communities, which often differ for boys and girls. Doing this well helps teams design strategies that target the real drivers of behaviour.

HOW?

We build a comprehensive picture of adolescent decision-making across the social-ecological model, including barriers at individual, relationship and community levels. In practice, this means:

- **Co-design formative research** with adolescents using participatory and youth-friendly methods.
- **Assess norms and social influences** shaping behaviours of both boys and girls and different segments of adolescents.
- **Explore relationship dynamics** such as communication, love, power and decision-making.
- **Map information ecosystems** to identify what adolescents know, where they get information (and disinformation), and who they trust.
- **Unpack norms** using a structured framework (e.g. CARE's Social Norm Analysis Plot).
- **Synthesise findings** into actionable insights to inform segmentation, messaging and intervention design.

KEY RESOURCE: Access Afrobaromer's data – a country data set, a multi-country merged data set, a geocoded data set, or a free online data analysis tool. They also have numerous publications from short-format dispatches to in-depth analyses.



IN PRACTICE

MSI Mali used CARE's Social Norms Analysis Plot (SNAP) framework to understand and describe the primary social norms impacting adolescent SRHR. The analysis showed how influential peers were in shaping the shame that blocks adolescents from using contraception and also in being part of the solution. The project used a human-centred design approach to develop a toolkit for peer educators called ***Dogoli Taala*** (meaning 'no taboos' in Bambara) that explicitly sought to address peer pressure.

Case study: A Comic, A Card Game and Real Talk

2. Use Data-Driven Segmentation

WHY?

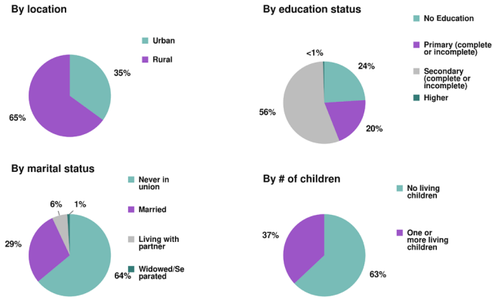
Adolescents are not a single, uniform group. They have different needs, motivations, and barriers shaped by age, gender, life stage, relationship status and geography. Using data to segment audiences helps ensure SBC strategies are relevant, targeted, and more likely to change behaviour. It also allows programmes to intentionally prioritise adolescents facing the greatest inequities.

HOW?

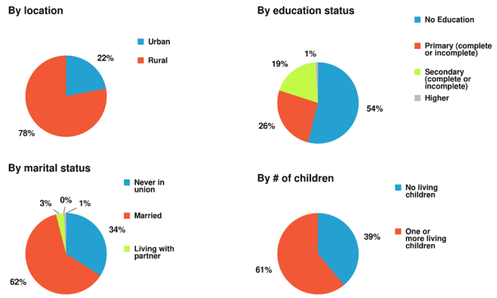
We use data and insights to define clear audience segments and tailor approaches accordingly. In practice, this means:

- **Start with existing data** to identify priority segments based on demographics and behaviours, using sources such as DHS data and MSI's own routine data.
- **Apply a gender lens to segmentation** by distinguishing the different needs, roles and behaviours of girls and boys, as well as influencing adults.
- **Focus on equity** by explicitly identifying and understanding adolescents most affected by inequality and discrimination, such as adolescents living with a disability.
- **Prioritise and target segments** with the highest unmet need, based on the available data
- **Apply MSI's Behaviour Change Framework** to understand key drivers, barriers and opportunities for each segment.
- **Develop audience personas** to bring segments to life, using formative research to create clear profiles (e.g. needs, barriers, media habits, decision influences).

MALI



SIERRA LEONE



IN PRACTICE

In 2020, MSI conducted a segmentation analysis of unmet need among adolescents in 23 countries using DHS and other data.

The analysis segmented adolescents on a variety of ideational and demographic factors and used this data to identify key behavioural objectives based on MSI's Behaviour Change Framework. The analysis illustrated how the adolescent unmet need, and thus programming implications, vary significantly by country context.

3. Meet Adolescents Where They Are with Tailored Messaging

WHY?

Adolescents are more likely to engage with and act on information that feels relevant, relatable and designed for them. Generic messaging fails to resonate and limits impact. Meeting adolescents where they are – physically, socially and digitally – helps build trust, strengthen brand recognition, and connect them more effectively to services.

HOW?

We design and deliver SBC that is youth-centred, context-specific, and clearly linked to services. In practice, this means:

- **Co-create with adolescents** to ensure messaging, tone, and channels are in line with their realities and preferences, avoiding terms that don't resonate (e.g. "family planning").
- **Tailor messaging** to audience segments (e.g. in-school vs out-of-school, married vs. unmarried adolescents, boys and girls).
- **Reach youth in key settings**, including in schools through coordinated CSE delivery with government and expert partners.
- **Blend digital and in-person** approaches, based on an understanding of where the target segment accesses information.
- **Ensure digital interventions** consider ethics, safety, equity, sustainability and data privacy.
- **Adapt mobilisation** for youth, training mobilisers in youth-friendly engagement and equipping them with tailored tools.
- **Use male and female peers effectively** as mentors, facilitators and referral agents – not primary contraceptive counsellors.
- **Track exposure to wider (mis)information** about contraception and abortion and respond rapidly through trusted messengers.



IN PRACTICE

Through a human-centred design process, MSI Kenya created the Future Fab brand using aspirational messaging to encourage adolescent contraceptive use, as well as engaging with parents, community leaders and county governments and conducting health worker values clarification sessions. Future Fab had the most success with urban, unmarried, pre-childbearing adolescent women and led to a ten-fold increase in adolescent visits to MSI Kenya clinics.

Case study: Future Fab: Helping the next generation of Kenyan girls have a fabulous future

4. Use Menstrual Health as an Entry Point

WHY?

Menstrual health is often a more acceptable and less sensitive starting point for conversations with adolescents and their influencers than contraception or abortion. Gatekeepers, such as parents, teachers and community leaders, tend to be more receptive to this topic, making it a practical way to build trust. It also provides a natural bridge into broader discussions on fertility, sexuality and reproductive health.

HOW?

We use menstrual health as a starting point to open wider conversations and connections to services. In practice, this means:

- **Start with menstrual health** discussions when engaging adolescents and their influencers to build comfort and trust.
- **Use it as a bridge** to introduce topics like fertility, the menstrual cycles and pregnancy risk.
- **Equip frontline actors and mobilisers** with tools to confidently transition from menstrual health to broader sexual health topics.



IN PRACTICE

In Timor-Leste and Papua New Guinea, the Keeping Girls in School Through Improved Reproductive and Menstrual Health project (2017-2021) integrated menstrual health education with comprehensive sexuality education, improving girl-friendly WASH facilities, and expanding access to SRH services. The project, delivered in partnership by MSI Australia and WaterAid, supported over 57,000 girls, boys, and adults to have increased access to WASH and SRHR information, facilities, and contraception services. Over 12,500 women and girls are using their choice of contraception and over 3,000 students are accessing girl-friendly WASH facilities in schools. Innovations such as anemia testing engaged adolescents in health services, creating safe pathways to discuss needs. Ultimately, positioning menstrual health within a holistic, cross-sectoral approach improved school attendance, reduced stigma, and increased access to SRH services, highlighting its value as a strategic gateway for adolescent health interventions.

Learn more: Programming insights from the ‘Keeping Girls in School Through Improved Reproductive and Menstrual Health’ project.

5. Leverage Key Life Events

WHY?

Adolescents are more open to new information and behaviour change at key transition points in their lives. These moments often bring new questions, needs and interactions with services, creating a window of opportunity to influence decisions and connect adolescents to SRH support.

HOW?

We identify and design interventions around key transition points in adolescents' lives. In practice, this means:

- **Map key transition points** (e.g. starting a new school year, marriage, first birth, entering the work force).
- **Align messaging and services** to these moments so support is timely and relevant.
- **Integrate SBC into existing touchpoints** (e.g. schools, health visits, community events).
- **Equip providers and frontline actors** to respond to adolescents' needs at these moments with youth-friendly information, referrals and services.



IN PRACTICE

MSI Sierra Leone's Back to School Campaign is an annual mixed-media campaign. Using radio commercials and school talks, adolescents are referred to youth-friendly services, delivered either by MSI teams in the schools themselves or at the local health centre. Every year when the campaign is delivered, the percentage of adolescent clients taking up a service spikes: during the campaign, over 50% of clients served by our mobile outreach teams are adolescents, compared to an average of 40% the rest of the year.

6. Integrate Gender Norms with a Life Course Lens

WHY?

Gender norms shape adolescents' choices, relationships, and access to SRH services from an early age, and their influence evolves across the life course. Harmful norms can limit autonomy, restrict mobility, and reduce access to information and care. Addressing gender norms helps remove these barriers and supports adolescents to make informed choices about their health.

HOW?

We address gender norms deliberately across all stages of adolescence and within the wider system around them. In practice, this means:

- **Identify key gender norms** influencing behaviours, roles and decision-making across different adolescent life stages for both boys and girls.
- **Tailor information and approaches for younger vs. older adolescents** based on their distinct needs and sexual behaviours.
- **Design messaging and activities specifically for adolescent boys** to address factors shaping their perceptions of contraception, abortion, decision-making, consent and equitable relationships.
- **Integrate gender transformative approaches** that challenge restrictive norms and promote equitable relationships into existing community engagement interventions.
- **Ensure inclusive approaches** that consider how gender intersects with other factors (e.g. disability, poverty, geography).



IN PRACTICE

MSI's ***La Famille Idéale*** intervention engages married adolescents in discussion about contraception using a set of family-oriented activities, including board games and conversation cards. These playful, accessible tools help adolescent girls and their spouses talk about their hopes for the future. When applied in Burkina Faso we saw a 25% increase in adolescents taking up contraception. As the approach has evolved and rolls out across Sahel countries, MSI has more intentionally integrated gender transformative messaging, such as promoting couple communication and preventing gender-based violence, leading to critical reflection of community norms.

For more information: La Famille Idéale

7. Activate Supportive Influencers

WHY?

Without supportive relationships and environments, changes in knowledge or attitudes are unlikely to translate into sustained behaviour change. Engaging influential community members helps reduce stigma, prevent backlash, shift norms, and create the support adolescents need to access SRH services.

HOW?

We work with the people and structures around adolescents to build a supportive environment for change. In practice, this means:

- **Get community leader buy-in,** thinking about framing to help adolescents in their community achieve their goals.
- **Build knowledge and skills among community leaders** (e.g. traditional, religious, women's groups, youth groups) to foster trusted gatekeepers, role models and champions.
- **Engage influential adults** (e.g. parents, caregivers, aunts/uncles) to build supportive attitudes, communication and decision-making.
- **Treat engagement as an ongoing process,** working with local partners at every stage rather than one-off activities.
- **Leverage peer influence** as part of a broader ecosystem of support around adolescents.
- **Plan for resistance and change,** adapting approaches in response to community dynamics, backlash or leadership shifts.



IN PRACTICE

MSI Zambia shares local statistics (such as adolescent antenatal care attendance or deliveries) with community leaders during engagement meetings to highlight issues associated with teenage pregnancy. In addition, community leaders are engaged in a 'path game' activity to understand the adolescent SRH journey and the challenges they face. These are exercises that build empathy and understanding among leaders, allowing them to walk in the shoes of young women and understand how the rights of adolescents align with the priorities of the community.

8. Mobilise High-Impact Referral Networks

WHY?

Adolescents are most likely to act on information and seek services when it comes through people and channels they already trust. Not all influencers carry the same weight. Identifying and strengthening the most influential referral pathways helps ensure adolescents are guided to the right services at the right time. Strong referral networks also help to bridge the intention to action gap, making it easier for adolescents to move from awareness to using services.

HOW?

We identify and strengthen the referral pathways that matter most to adolescents. In practice, this means:

- **Map existing networks and touchpoints** to understand where adolescents already seek support.
- **Prioritise high-influence actors** and equip them as referral agents linked to MSI services.
- **Leverage existing structures** rather than creating new ones wherever possible, building on trusted community systems.
- **Create easy-to-use reminders** for adolescent clients to refer friends, through tailored cards and adolescent-friendly rewards.
- **Build referral mechanisms in government structures** with clear roles and resources to sustain engagement.
- **Position MSI contact centres (hotlines)** as a key hub within the referral network and continuum of care.
- **Ensure contact centres** have adolescent responsive staff, youth-friendly communication channels (e.g. chat), and up-to-date locations of adolescent-friendly service delivery points.



IN PRACTICE

In DRC, MSI used human-centred design to develop the 'Straight Talk' approach, which included Big Sister peer mobilisers – young women only slightly older than the adolescents they are supporting. The Big Sisters hold one-on-one conversations with adolescents to address myths and misconceptions about contraception, and provide personalised referral cards to an MSI Lady (service provider). This ensures that adolescents have access to confidential contraceptive counselling and services.

Case study: Straight-talking Big Sisters
Impact Story: That's what big sisters are for



Deliver

Provide high-quality, adolescent-responsive services.

DELIVER means giving high-quality, confidential and non-judgmental services to adolescents.

This domain focuses on client-centred choice, adolescent-responsive staff, integrated service models and non-traditional pathways to care. Even strong demand will not translate into impact if services do not meet adolescents' needs.

Recommended actions:

1. Deliver gold-standard, client-centred choice
2. Build an adolescent-competent workforce
3. Integrate adolescent-responsive care into existing service models
4. Strengthen data systems for adolescent-responsive care
5. Create non-traditional pathways to services
6. Connect adolescents through MSI contact centres

1. Deliver Gold Standard, Client-Centred Choice

WHY?

MSI is committed to ensuring informed choice for all adolescents regardless of marital status or parity, including access to long-acting and reversible methods (LARCs) and abortion. While MSI's core quality metrics (Abortion Quality Index, Client-Centred Care metric, Clinical Quality Metric) are not adolescent-specific, they are critical for ensuring adolescent-responsive care.

HOW?

We deliver high-quality, equitable services that prioritise adolescent choice, privacy, and rights. In practice, this means:

- **Ensure confidentiality** by providing private counselling spaces and not disclosing information without consent.
- **Adapt counselling for adolescents based on their feedback** to simplify content and use youth-friendly language.
- **Provide unbiased counselling,** including the full method mix, without restrictions based on age, marital status or parity.
- **Ensure equitable access** by proactively adapting services for underserved adolescents (e.g. those with disabilities, living with HIV, sexual and gender minorities, displaced etc).
- **Support self-care options,** including self-administered injectable contraception, over-the-counter contraceptive methods, emergency contraception, and condoms.
- **Uphold safeguarding standards** by complying with MSI's Child Safeguarding Policy and ensuring safe, rights-based care for clients under 18.



KEY RESOURCE:

MSI's Inclusion Readiness Assessment Tool provides a rapid assessment of the readiness of a service delivery site and its staff to provide inclusive healthcare, focusing primarily on adolescents and clients with disabilities. The tool includes three parts: 1) Assessment of the client journey at a healthcare facility; 2) Observation of an SRH counselling session; and 3) Feedback on community engagement approaches. Findings from the assessment can be used to inform an intervention or identify gaps and directly inform subsequent training or supportive supervision and mentorship schemes.

2.Build an Adolescent-Competent Workforce

WHY?

Adolescents' experiences depend on how confident and supported staff feel to provide respectful, non-judgemental care. Providers and frontline teams often reflect the same norms as the communities they serve and must also navigate national-level policies around adolescent access to contraception and safe abortion care. These factors can lead to biases that impact services.

HOW?

We strengthen the capability and environment for all staff to deliver adolescent-responsive care, including access to long-acting contraceptive methods and abortion, where legally permitted. In practice, this means:

- **Train providers and support staff** on adolescent-responsive, rights-based care and child safeguarding.
- **Address biases in attitudes and norms** through VCAT and provider behaviour change approaches.
- **Strengthen confidentiality** in practice through training and clear protocols to protect adolescents' privacy and rights.
- **Provide supportive supervision** and monitoring to reinforce skills, build confidence, and address challenges over time.
- **Use provider assessments and routine data** to identify gaps and tailor ongoing training and support.



IN PRACTICE

In Uganda, MSI worked with Ideas42 to pilot a 'Refer-a-Friend' intervention to increase adolescent access to contraception through peer referrals and youth-friendly clinic cues. Across MSI's social franchised clinics, the model led to a 45% increase in adolescent clients overall, demonstrating the power of peer influence. However, results were notably stronger in 'Core+' sites, where referral activities were combined with provider training on youth-friendly services. These clinics saw a 62% increase in adolescent clients (vs. 26% in referral-only sites), highlighting that equipping providers with training alongside generating awareness and demand significantly amplifies impact.

Case study: Empowering adolescent girls as peer advocates for family planning

3.Integrate Adolescent Responsive Care into Existing Service Models

WHY?

Adolescents access services in different ways depending on their needs, preferences and constraints. A systems approach that embeds adolescent-responsive care across all MSI service delivery channels ensures broader reach, consistency and sustainability. Isolated or stand-alone youth interventions are difficult to scale and maintain.

HOW?

We institutionalise adolescent-responsive elements into all MSI services. In practice, this means:

- **Avoid separate 'youth-only' spaces** that are difficult to sustain or scale.
- **Consider alternative ways to provide stigma-free access in existing spaces** such as through scheduled clinic hours for adolescents.
- **Co-locate MSI services** in and around schools and other youth settings to improve access.
- **Ensure services are organised around adolescent needs** for privacy, respectful care, and ensuring choice.
- **Leverage the strength of each service delivery approach** to reach different adolescent segments effectively.
- **Address gender-based barriers,** such as mobility restrictions for girls or opening hours outside of school time, and tailor service response accordingly.

MSI APPROACH	HOW THIS WORKS IN PRACTICE
Outreach	• Bring services closer to adolescents by providing services near schools • Reach out-of-school adolescents by providing services in communities and near other youth spaces
Public sector strengthening	• Reduce cost barriers through free or subsidised services, waivers, or vouchers • Support provider values clarification and attitudes transformation (VCAT) on adolescent-responsive care • Complement adolescent adaptations with broader support for provider capacity, supervision, commodity management and facility readiness
MSI Ladies	• Provide discreet, in-home services that meet adolescents' needs for privacy • Build trust through personalised, community-based care
Centres	• Use waivers or flexible pricing to improve affordability for adolescents • Build a trusted reputation as adolescent-friendly service providers over time
Social marketing	• Emphasise privacy and anonymity • Enable self-care options (e.g. emergency contraception, self-injection where permitted)

Examples of Adolescent-Response Services Across MSI's Delivery Channels

Outreach	In Sierra Leone, MSI's outreach teams adapted their services by extending service hours and ensuring locations are convenient to schools, to make it easier for adolescents to access care.
Public sector strengthening	In Ghana, MSI worked with the Ghana Health Service Adolescent Health Unit to harmonise the youth-friendly services training curriculum for providers and mobilisers. This led to equity and efficiency gains in public sector sites: the average monthly number of adolescent clients increased from 591 in 2020 to 6,026 in 2023 and cost per client reduced from £4.70 in 2020 to less than £3 in subsequent years.
MSI Ladies	In the DRC, MSI designed a peer mobilisers approach - MSI Grandes Soeurs (MSI Big Sisters) – who engage adolescents, connecting young people to youth-responsive MSI Ladies (qualified midwives who provide services). This direct connection helps to ensure that adolescents have access to trained, discreet and confidential contraceptive counseling. In 2025, MSI Ladies in the DRC served over 142,000 clients, of which 31% were adolescents.
Centres	In Uganda, where contraceptive unmet need among adolescents was high, MSI used donor funding to remove cost barriers for adolescents at our social franchise clinics through vouchers. Even after the voucher programme ended, adolescent services at these sites was sustained thanks to ongoing referrals among adolescents who had come to trust these providers.



4.Strengthen Data Systems for Adolescent-Responsive Care

WHY?

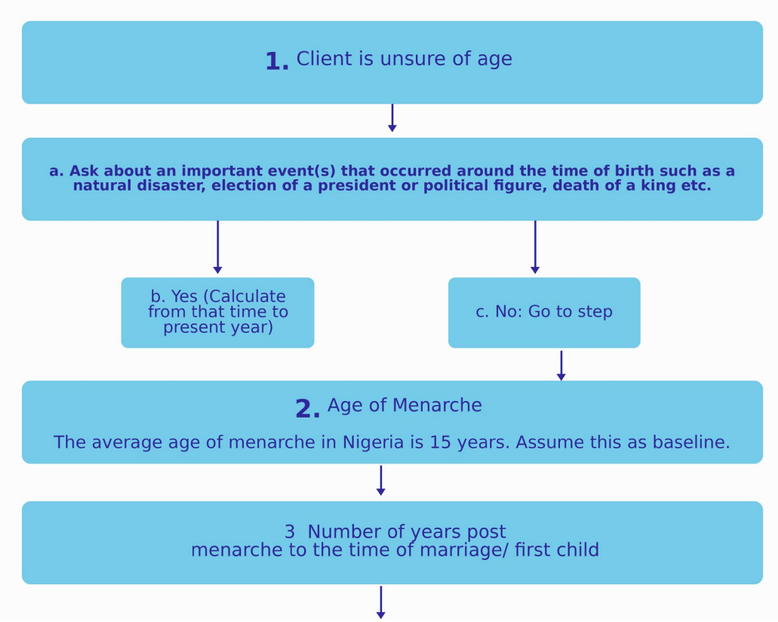
Accurate, timely data is essential to understand whether adolescents are truly being reached and served well. Weak or incomplete data can mask gaps and reinforce assumptions. Strengthening data systems helps reduce bias, improve service quality, and ensure adolescents are visible in decision-making.

HOW?

We strengthen data collection and use across our service delivery channels to better understand and respond to adolescents' needs. In practice, this means:

- **Improve data collection tools and processes** to accurately capture age without making assumptions and identify adolescent clients (e.g. to estimate age when unknown).
- **Disaggregate routine and quality data** (e.g. MSI's core quality metrics) by age to assess adolescent experience and outcomes.
- **Integrate adolescent indicators** into routine monitoring systems to ensure visibility and accountability.
- **Use data to improve care** by identifying gaps in adolescent reach, experience, method, and continuation and adapting services accordingly.

MSI Nigeria's procedure for determining a client's age when the client does not know



IN PRACTICE:

In Nigeria, where approximately 70% of children's births are not registered, many young people do not know their exact age. In response, MSI developed a Standard Operating Procedure to estimate age, using prompts such as major events near their birth, years since menarche and age of children. This reduces bias and supports accurate identification of adolescents that in turn helps shape adolescent-responsive care.

5.Create Non-Traditional Pathways to Care

WHY?

Adolescents often face barriers, particularly stigma, cost and confidentiality concerns, that limit their access to contraception and abortion services. Integrating SRHR into other, more acceptable or routine services can create alternative entry points that build trust and make it easier for adolescents to engage with care.

HOW?

Where feasible, we use integrated services as entry points to connect adolescents to reproductive health services. In practice, this means:

- **Adapt to context** by prioritising the most relevant integrated services for different country contexts and adolescent needs.
- **Link with mobilisation approaches** (e.g. menstrual health messaging) to create a seamless continuum.
- **Use other services** (e.g. HIV services, HPV vaccines, STI testing and treatment, menstrual health care) to introduce contraception or abortion information in an effective way.
- **Ensure clear referral pathways** from other services.
- **Train providers to identify opportunities** and sensitively transition conversations to SRH needs.



IN PRACTICE:

MSI Nepal engaged mothers' groups and partnered with other organisations to promote HPV DNA testing and HPV vaccination through targeted awareness initiatives. The campaigns positioned HPV vaccination as a life-saving investment for daughters and all women in the family, emphasising that HPV vaccination is an effective preventive measure against cervical cancer.

6.Connect Adolescents Through MSI Contact Centres

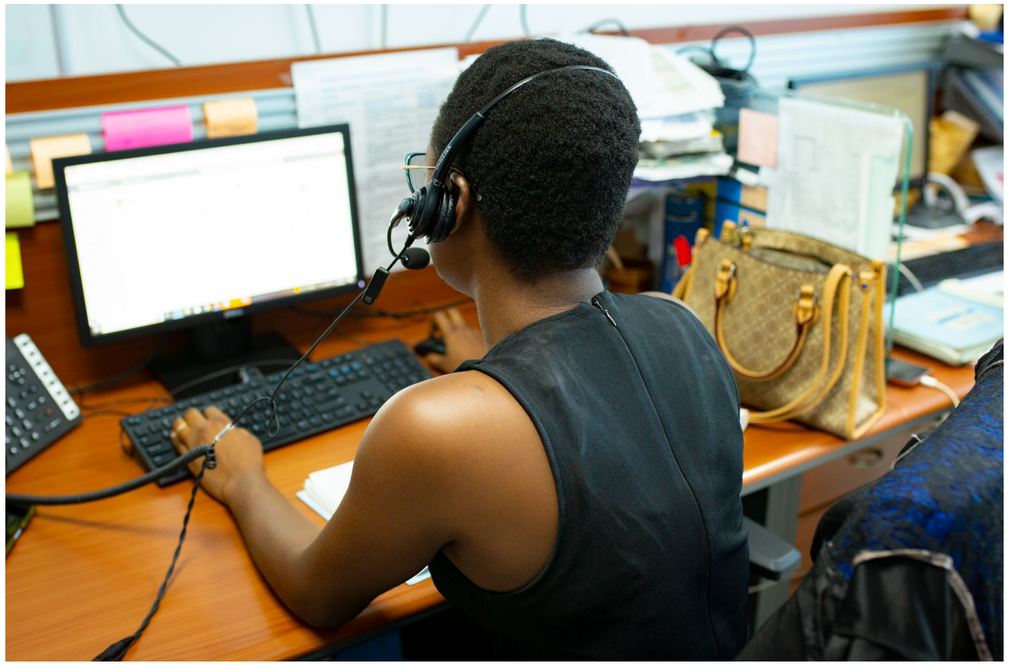
WHY?

For many adolescents, MSI's contact centres (toll-free hotlines) can be a more accessible first step than visiting a health facility. Young people have questions about relationships, contraception, pregnancy, STIs or other issues but may feel embarrassed, uncertain or afraid to seek care in person. Providing confidential information and tailored referrals via these hotlines can bridge the gap between awareness and services.

HOW?

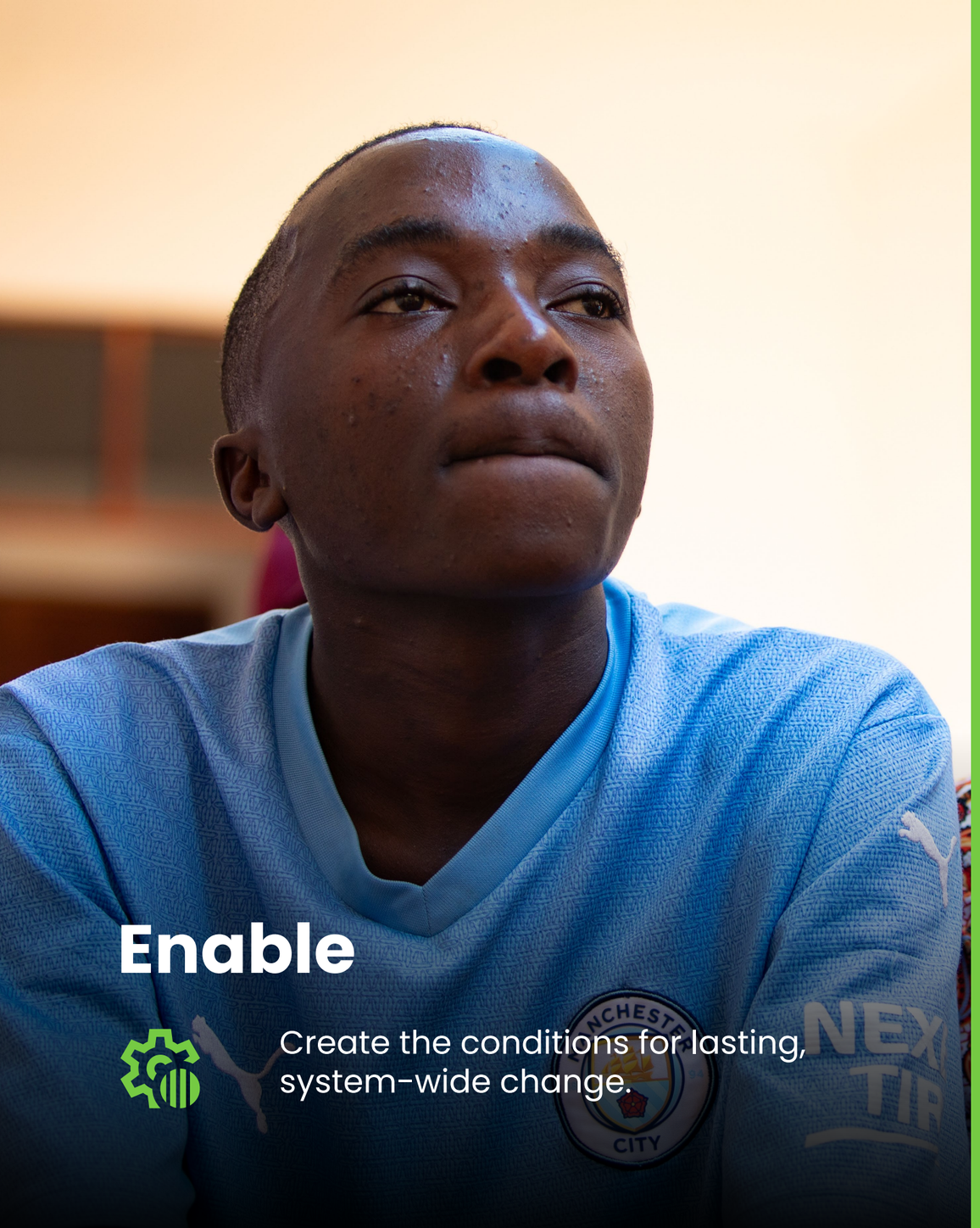
We design contact centres as adolescent-responsive information and referral hubs. In practice, this means:

- **Provide multiple ways to access** the hotline, including toll-free phone, SMS, WhatsApp and other social media platforms.
- **Train staff** on adolescent-responsive communication, confidentiality, safeguarding and non-judgemental counselling.
- **Use youth-friendly language** and communication styles that are relevant, accessible and easy for adolescents to understand.
- **Maintain up-to-date referral information** on adolescent-friendly MSI and partner services.
- **Promote contact centre services** through SBC and marketing campaigns, outreach events and other referral pathways.
- **Use contact centre data and feedback** to identify common concerns, barriers and information gaps among adolescents to inform programme improvements.



IN PRACTICE:

In Nigeria, MSI includes the contact centre toll-free and WhatsApp numbers on all creatives, branding, promotional items and communication materials. These are distributed to adolescents during in-school events, activities in hair salons and youth engagement activities. Social media and Google promotions by MSI Nigeria are another channel for reaching young people. In 2025, the contact centre engaged with 125,035 clients, of which 18% were adolescents.



Enable

Create the conditions for lasting, system-wide change.

ENABLE addresses the wider policy, systems and accountability environment needed for lasting change.

This domain focuses on removing policy barriers, translating policy into practice, and supporting youth-led accountability so adolescents can claim their rights and access services. Service delivery gains are difficult to sustain if laws, policies, financing and accountability systems do not support adolescent-responsive healthcare.

Recommended actions:

1. Advocate to remove policy barriers
2. Translate policy into action
3. Advance youth-led accountability

1. Advocate to Remove Policy Barriers

WHY?

Policies shape what services adolescents can access and how services are delivered. Supportive policies on comprehensive sexuality education and adolescent SRHR can create the conditions for equitable access and informed choice. Restrictive laws, such as consent requirements or limits on service provision, can exclude young people. Addressing these barriers is essential for sustainable, system-wide change.

HOW?

We work to strengthen the policy environment for adolescent access. In practice, this means:

- **Identify restrictive barriers** (e.g. consent requirements, limitations on method provision or service access).
- **Promote inclusion of boys and men** in relevant policies to avoid framing contraception as a woman's responsibility.
- **Engage policymakers and stakeholders** with evidence, human stories and programme learning to influence change.
- **Align with national strategies** to embed adolescent SRH within broader health and development agendas.



IN PRACTICE

MSI Ethiopia played a key role in shaping adolescent-inclusive guidelines through supporting the development of the national Roadmap to Reduce Teenage Pregnancy, which launched in June 2025. Participating in technical working groups on youth health and contraception, MSI consistently advocated for adolescent priorities. We worked closely with the Ministry of Health and UN partners to shape the roadmap using national and global data to demonstrate what works, as well as showcasing our own service delivery models (e.g. mobile outreach and adolescent-friendly services) as practical examples. Crucially, MSI facilitated youth participation in consultations and workshops, helping align services and policies with adolescents' real needs.

2. Translate Policy into Practice

WHY?

Policy change alone is not enough. Gaps often remain between what policies allow and what providers actually do. Without clear understanding and confidence, providers may default to restrictive practices. Ensuring providers and staff understand and feel empowered to apply policies that support adolescent access is critical.

HOW?

We support providers and teams to operationalise policies in service delivery. In practice, this means:

- **Build awareness of legal and policy frameworks** among MSI teams, providers and supported public sector providers.
- **Clarify policy changes and implications** to ensure consistent, up-to-date understanding of providers and frontline staff.
- **Integrate policy guidance** into training and supervision to reinforced correct practices.



IN PRACTICE

In the DRC, MSI supports the translation of policy commitments into real adolescent access to services by strengthening youth advocacy and government implementation pathways. MSI helps youth-led and civil society organisations disseminate government commitments on adolescent and youth sexual and reproductive health, enabling them to advocate for their implementation. For example, technical and financial support for meetings and joint campaigns, and building young people's capacity to engage authorities and generate public communications. On the policy side, MSI works directly with relevant authorities (including ministries of health, education, youth, and social affairs) to support the effective rollout of government commitments. Overall, MSI has served as a bridge between policy and practice by empowering youth actors to hold systems accountable while also supporting authorities to turn commitments into measurable progress in adolescent access and service delivery.

3. Advance Youth-Led Accountability

WHY?

When young people can voice their experiences and hold systems accountable, it improves service quality, equity and trust. Youth-led social accountability strengthens health systems by ensuring services are responsive to adolescents' needs and rights.

HOW?

We support adolescents to actively engage in holding systems accountable. In practice, this means:

- **Enable youth participation** in feedback and accountability mechanisms (e.g. community scorecards, forums).
- **Strengthen platforms for youth** to engage with service providers and decision-makers.
- **Support constructive dialogue** between adolescents, providers and policymakers.
- **Use feedback to drive improvements** in service quality, responsiveness and equity.



IN PRACTICE

During the Youth for Health project in Kenya, MSI's partner YSW trained adolescent champions to lead 'community scorecards' that assessed health services. Youth actively collected evidence through focus groups and interviews, identifying gaps in family planning, youth-friendly services, and gender-based violence responses. They played a central role in amplifying adolescent concerns – such as lack of privacy, commodity stockouts, and unfriendly providers – and in co-developing action plans with service providers. This approach demonstrates how empowered youth can drive accountability, influence service improvements, and ensure health systems are more responsive to their needs and rights.

Report: Community Scorecard Report 2023- West Pokot

Bibliography

Bajracharya, A., Veasnakiry, L., Rathavy, T., & Bellows, B. (2016). Increasing of Long-Acting Reversible Contraceptives in Cambodia Through a Voucher Program: Evidence From a Difference-in-Differences Analysis. ***Global Health: Science and Practice,*** 4(Suppl 2), S109. https://doi.org/10.9745/GHSP-D-16-00083

Beckwith, S., Chandra-Mouli, V., & Blum, R. W. (2024). Trends in Adolescent Health: Successes and Challenges From 2010 to the Present. ***Journal of Adolescent Health,*** 75(4), S9–S19. https://doi.org/10.1016/j.jadohealth.2024.04.015

Blanc, A. K., Tsui, A. O., Croft, T. N., & Trevitt, J. L. (2009). Patterns and Trends in Adolescents' Contraceptive Use and Discontinuation in Developing Countries and Comparisons With Adult Women. ***International Perspectives on Sexual and Reproductive Health,*** 35. https://www.guttmacher.org/journals/ipsrh/2009/patterns-and-trends-adolescents-contraceptive-use-and-discontinuation

Bradley, S. E. K., & Shiras, T. (2022). Where Women Access Contraception in 36 Low- and Middle-Income Countries and Why It Matters. ***Global Health: Science and Practice,*** 10(3). https://doi.org/10.9745/GHSP-D-21-00525

Calhoun, L. M., Mandal, M., Onyango, B., Waga, E., McGuire, C., Zulu, E. M., van den Akker, T., Benova, L., Delvaux, T., & Speizer, I. S. (2022). Contraceptive method use trajectories among young women in Kenya: A qualitative study. ***Frontiers in Global Women's Health,*** 3, 973971. https://doi.org/10.3389/fgwh.2022.973971

Chandra-Mouli, V., Lane, C., & Wong, S. (2015). 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,*** 3(3), 333–340. https://doi.org/10.9745/GHSP-D-15-00126

Chandra-Mouli, V., McCarraher, D. R., Phillips, S. J., Williamson, N. E., & Hainsworth, G. (2014). Contraception for adolescents in low and middle income countries: Needs, barriers, and access. ***Reproductive Health,*** 11(1), 1. https://doi.org/10.1186/1742-4755-11-1

Corneliess, C., Cover, J., Secor, A., Namagembe, A., & Walugembe, F. (2023). Adolescent and Youth Experiences With Contraceptive Self-Injection in Uganda: Results From the Uganda Self-Injection Best Practices Project. ***The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine,*** 72(1), 80–87. https://doi.org/10.1016/j.jadohealth.2022.08.010

Hémono, R., Gatare, E., Kayitesi, L., Hunter, L. A., Packel, L., Ippoliti, N., Cerecero-García, D., Contreras-Loya, D., Gadsden, P., Bautista-Arredondo, S., Sayinzoga, F., Mugisha, M., Bertozzi, S. M., Hope, R., & McCoy, S. I. (2024). Effect of a digital school-based intervention on adolescent family planning and reproductive health in Rwanda: A cluster-randomized trial. ***Nature Medicine,*** 1–8. https://doi.org/10.1038/s41591-024-03205-1

High Impact Practices in Family Planning (HIPs). Adolescent-Responsive Contraceptive Services: Institutionalizing adolescent-responsive elements to expand access and choice. Washington, DC: HIPs Partnership; 2021 March. Available from: http://www.fphighimpactpractices.org/briefs/adolescent-responsive-contraceptive-s

High-Impact Practices in Family Planning (HIPs). Meaningful Adolescent and Youth Engagement and Partnership in Sexual and Reproductive Health Programming: A Strategic Planning Guide. Washington, DC: HIP Partnership; 2022, March Available from: https://www.fphighimpactpractices.org/guides/meaningful-adolescent-and-youth-engagement

Kalyesubula, R., Pardo, J. M., Yeh, S., Munana, R., Weswa, I., Adducci, J., Nassali, F., Tefferi, M., Mundaka, J., & Burrowes, S. (2021). Youths' perceptions of community health workers' delivery of family planning services: A cross-sectional, mixed-methods study in Nakaseke District, Uganda. ***BMC Public Health,*** 21(1), 666. https://doi.org/10.1186/s12889-021-10695-y

Krass, P., Sieke, E. H., Joshi, P., Akers, A. Y., & Wood, S. M. (2023). Pediatric Resident Perspectives on Long-Acting Reversible Contraception Training: A Cross-Sectional Survey of Accreditation Council for Graduate Medical Education Trainees. ***Journal of Adolescent Health,*** 72(6), 964–971. https://doi.org/10.1016/j.jadohealth.2023.01.016

Lane, C., Ferguson, B. J., & Chandra-Mouli, V. (2024). Is a search for game changers preventing us from focusing on the necessary tasks of systems strengthening and norm change to facilitate adolescent contraceptive use? ***Reproductive Health,*** 21(1), 125. https://doi.org/10.1186/s12978-024-01847-5

Meuwissen, L. E., Gorter, A. C., Kester, A. D., & Knottnerus, J. A. (2006). Does a competitive voucher program for adolescents improve the quality of reproductive health care? A simulated patient study in Nicaragua. ***BMC Public Health,*** 6(1), 204. https://doi.org/10.1186/1471-2458-6-204

Plesons, M., Cole, C. B., Hainsworth, G., Avila, R., Va Eceéce Biaukula, K., Husain, S., Janušonytė, E., Mukherji, A., Nergiz, A. I., Phaladi, G., Ferguson, B. J., Philipose, A., Dick, B., Lane, C., Herat, J., Engel, D. M. C., Beadle, S., Hayes, B., & Chandra-Mouli, V. (2019). Forward, Together: A Collaborative Path to Comprehensive Adolescent Sexual and Reproductive Health and Rights in Our Time. ***The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine,*** 65(6S), S51–S62. https://doi.org/10.1016/j.jadohealth.2019.09.009

Sawyer, S. M., Afifi, R. A., Bearinger, L. H., Blakemore, S.-J., Dick, B., Ezeh, A. C., & Patton, G. C. (2012). Adolescence: A foundation for future health. ***The Lancet,*** 379(9826), 1630–1640. https://doi.org/10.1016/S0140-6736(12)60072-5

Silverman, J. G., Brooks, M. I., Aliou, S., Johns, N. E., Challa, S., Nouhou, A. M., Tomar, S., Baker, H., Boyce, S. C., McDougal, L., DeLong, S., & Raj, A. (2023). Effects of the reaching married adolescents program on modern contraceptive use and intimate partner violence: Results of a cluster randomized controlled trial among married adolescent girls and their husbands in Dosso, Niger. ***Reproductive Health,*** 20(1), 83. https://doi.org/10.1186/s12978-023-01609-9

Tembo, M., Renju, J., Weiss, H. A., Dauya, E., Gweshe, N., Ndlovu, P., Nzombe, P., Chikwari, C. D., Mavodza, C. V., Mackworth-Young, C. R. S., A Ferrand, R., & Francis, S. C. (2022). Integration of a menstrual health intervention in a community-based sexual and reproductive health service for young people in Zimbabwe: A qualitative acceptability study. ***BMC Health Services Research,*** 22(1), 421. https://doi.org/10.1186/s12913-022-07818-5

Wagner, Z, Corrina Moucheraud, Manisha Shah, Alexandra Wollum, Willa H. Friedman, and William H. Dow. Reducing Bias Among Health Care Providers: Experimental Evidence From Tanzania, Burkina Faso, and Pakistan NBER Working Paper No. 31269 May 2023, Revised September 2024 JEL No. D12, I11, I12, O12. https://www.nber.org/system/files/working_papers/w31269/w31269.pdf

World Health Organization (2025). WHO guideline on preventing early pregnancy and poor reproductive outcomes among adolescents in low- and middle-income countries. Geneva. Licence: CC BY-NC-SA 3.0 IGO. WHO guideline on preventing early pregnancy and poor reproductive outcomes among adolescents in low- and middle-income countries

World Health Organization (2025). Global standards for quality health care services for adolescents. Geneva. Global standards for quality health care services for adolescents

World Health Organization (2023). WHO, Global Accelerated Action for the Health of Adolescents (AA-HA!)—Second edition. (n.d.). https://www.who.int/publications/i/item/9789240081765

Woog V and Kågesten A, The Sexual and Reproductive Health Needs of Very Young Adolescents Aged 10–14 in Developing Countries: What Does the Evidence Show? New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/srh-needs-very-young-adolescents-in-developing-countries

MSI REPRODUCTIVE CHOICES

1 Conway Street, Fitzroy Square,
London W1T 6LP, United Kingdom

+44 (0)20 7636 6200

partnerships@msichoices.org

Registered charity number: 265543
Company number: 1102208