

Barriers to the involvement of clients in family planning service development: lessons learnt from experience

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(Accepted 4 August 2003)

Journal of Family Planning and Reproductive Health Care 2003; **29**(4): 199–203

Abstract

Context. Client involvement in service development underpins the Department of Health strategy for sexual health improvement in the UK. Participatory approaches to user consultation have been effectively piloted in this context but the responses of service providers to these data are rarely documented.

Objectives. Recruiting clinic users and training clinic users to interview their fellow clinic users on sexual health service use and to document staff responses to the results of this consultation.

Design. Clinic users interviewed young clinic users (aged <25 years) using a time line to generate a description of their first clinic visit. The results were presented to staff with a questionnaire requesting their views.

Results. Forty-six clients were interviewed. More comments were made on the waiting room than any other aspect of clinic use. These comments were almost exclusively negative. The waiting room was described as uncomfortable, insufficiently confidential and lacking refreshment and entertainment. Most clients were happy with the clinical consultation. Both positive and negative comments on this aspect of service use related to staff attitudes. The priorities of clients and staff were different and potentially conflicting. Whereas staff are keen that the waiting room should appear tidy, clients require refreshments or children's toys that generate mess. Staff see the clinical service as the most important aspect of a clinic visit while users may view their comfort while waiting for long periods as equally important.

Discussion. This methodology documents clients' experiences (positive and negative) of a specific service and generates practical suggestions for improvement. Further work is required to identify common goals for staff and clients. An iterative process of staff and client consultation may ensure that future service development proceeds in a direction that meets the needs of both groups.

Key message points

- Training clinic users to interview their fellow clinic users is an effective strategy to generate detailed descriptions of a specific service from a client's perspective.
- The priorities of staff and clients in family planning clinics may be different and conflicting.
- This may impede service development based on client consultation.
- User consultation strategies should aim to generate consensus between users and staff on appropriate directions for service development.

Introduction

The strategy for improving sexual health in the UK as set out in the Social Exclusion Unit Report on Teenage Pregnancy and the National Strategy for HIV and Sexual Health commits service providers to working in partnership with service users.^{1,2} This reflects the position of user involvement in service development as a central theme within the National Health Service (NHS) Plan.³ The rationale for this approach is that users provide views of service delivery problems that are different from those of clinicians or health service planners and may have innovative solutions to such problems. In addition, there is an assumption that involving users during development will result in more acceptable services and that greater openness about the process of development may create a better understanding of complex NHS issues.⁴ The challenges of user involvement include the investment required to recruit users from a wide range of backgrounds and to support their participation. In addition planners and service providers require support to respond to suggestions that may challenge accepted approaches to health service policy making, planning and delivery.⁵

Methodological considerations

The strategies described to involve users in health service development offer different levels of client involvement and can usefully be considered as part of a spectrum.⁶ At one extreme the views of users are sought on topics and with methods controlled by researchers, and at the other extreme participatory research strategies involve clients in all stages of the research process. Most strategies sit between these poles.

The most commonly used approach to user consultation is the client satisfaction survey. Surveys allow the rapid consultation of large numbers of service users but there is a growing body of evidence to suggest that they are limited tools for documenting experience of service use.^{7–11} Surveys consistently demonstrate high levels of satisfaction but a discrepancy has been recorded between the satisfaction expressed in questionnaires and reports of negative experiences from the same patients in qualitative interviews. Explanations for this include clients' perceptions that the health service was not responsible for their negative experience; for example, a long waiting time may be explained as the consequence of excessive demand. In addition, users are reluctant to criticise health professionals on whom they depend for medical care and many have low expectations of medical services.

Participatory approaches to sexual health service evaluation have been used to obtain user and provider views of contraceptive services in the UK.^{12–14} They offer

advantages in terms of their ability to generate practical suggestions for improving services to meet the needs of users. The ability of service providers to respond to the users' views collected is under-researched and further work in this area has been recommended.¹²

As part of the evaluation of a new model of sexual health service provision for young people we piloted one participatory approach to user consultation, namely the use of clinic users trained to interview their fellow clinic users (after Whitmore, 1994)¹⁵. We anticipated that this approach might be less intimidating to those service users with little formal education who might find it difficult to speak to university-trained researchers, but we were unsure about whether such an approach would be acceptable to users of a service where confidentiality is of such importance. We were also interested in service providers' responses to data collected in this way and in their capacity to implement users' suggestions. Our research aimed to:

- examine the feasibility of peer interviewers in family planning clinics (FPCs)
- compare the results of this approach with what is already known about users' views of contraceptive services
- explore staff views of, and responses to, this approach to user consultation.

Methods

Clinic users were trained to interview their fellow clinic users. Interviewers were recruited through posters in the clinic waiting room. Six clinic users responded and four were recruited. Two were youth workers, one had administration and reception experience, and the fourth was a photographer. They received two, 3-hour training sessions and then did one pilot interview each before a final training session to discuss their experience of the pilot. The training sessions included a practice interview with each other, a session on confidentiality and one on participatory interviewing techniques. They signed honorary contracts with the Trust that included a clause committing them to maintaining confidentiality. They were paid for attending the training sessions and received a fee per interview.

The interviews referred to clinic users' first ever visit to the service. Interviews were structured using a large sheet of paper. 'Need for help' signified the start of the interview and 'Mission accomplished' signified the end. These two points were connected by a time line. All events in between these two times were recorded on the left side of the paper and the feelings associated with these events were recorded on the right.

In addition to the flip chart paper interviewers worked with a large board painted with a brick wall and a tree. The bricks of the wall represented negative aspects of the service and the leaves of the tree represented its positive characteristics. As positive and negative aspects of the service were identified these were recorded (usually by the interviewee) on brick- or leaf-shaped Post-it® notes and attached to the painted board. The use of these props encouraged joint working: the interviewer working on the flip chart and interviewee working with the 'leaves' and 'bricks'. Together they decided what information was important and should be recorded.

Clinic users were recruited in the clinic waiting room by the interviewers. Any clinic user under the age of 25 years was eligible to be interviewed. Interviewees received a £10 gift voucher in acknowledgement of the time they had given to complete the interview. Since recruitment was done informally we have no data on the number or characteristics of respondents who refused to be interviewed. The interviews were conducted at the time of the clients' visit to the service. They were interviewed either while waiting to be seen or after the consultation.

A summary of the findings was presented to clinic managers and all clinic staff (doctors, nurses, receptionists and administrators) with the following questions:

- What do you think about this type of client satisfaction survey?
- Do you think that the clients' comments on the following aspects are justified?
- How could we improve the service in response to the clients' comments?

Written responses to the questionnaire were collated and analysed.

Analysis

The time lines of clinic use and the associated leaves and bricks were fully transcribed. The data from all interviews were then collated and arranged according to the key events of the visit, for example, 'time spent in the waiting room'. Themes were identified within these categories. The analysis focused on summarising the full range of the opinions expressed rather than focusing on frequent responses. Staff responses were treated in a similar way. Particular attention was paid to negative experiences of the service and barriers to service improvement. These were considered to be important since the former should drive service development and the latter may impede it.

Results

Forty-seven interviews were completed. All respondents except one were aged 25 years and under (see Table 1). The data from the one respondent aged over 25 years was excluded. The majority (40/46) of respondents were female and this reflects the sex distribution of clinic users. The ethnicity of respondents also reflects that of the local population with 16/46 respondents identifying themselves as White British, eight as Black Caribbean, six as Black British and six as Black African.

Accessing the clinic

Friends were important sources of information and support during the first clinic visit. Almost half (21/46) of the respondents reported visiting the clinic for the first time with a friend, usually someone already familiar with the service. Friends helped new clients find the clinic and explained clinic procedures. Relying on friends for support meant new clients often used services close to their friend's house or school rather than their own.

"First heard about the clinic through two school friends.... My first visit today I came in with two school friends after school. I live in X so I would travel by bus or train, it takes about 45 minutes to get here." (Female, 15 years)

Having travelled to visit their friend's clinic, clients may be reluctant to change once familiar with it. The woman quoted below had continued to travel half an hour to the clinic for 3 years and had never used her local clinic, partly because her friend used this one.

"Found out about clinic through a friend.... I have never used the local one. Travelled here on two buses, took about half an hour. I came to the clinic with a friend for the first time who showed me where it was."

(Female, 17 years, aged 14 years at the time of first clinic use)

Table 1 Age of respondents

Age (years)	Interviews (n)
<16	12
16–19	19
20–25	15
25+	1

Some who moved significant distances from the service reported travelling to use a service they knew.

"I am no longer local but I still use the clinic as it's familiar and not frightening to come here."

(Female, 23 years)

Waiting

Forty-three clients commented on the waiting room. Three comments were positive, seven were neutral and 34 comments were negative. Clients made more comments on the waiting room than any other topic.

Eight users commented on the institutional appearance of the waiting room and 20 on its décor. They described it as 'too clinical', 'looked like a doctor's surgery' or a library or 'feels like a hospital'. They made suggestions which would make the waiting area, 'more homely' or more 'cosy', for example, 'art on the walls', 'a nice, blue carpet', 'bright colours', plants, pictures or flowers. The data give a strong sense that although clients acknowledge that this is a clinic waiting room and that it looks like a clinic waiting room, they would prefer that it looked like something else. The suggestions for improvement suggest a preference for a waiting space resembling a communal living space in a private home.

Many clients made suggestions for improving their physical comfort while waiting. Six suggested comfortable chairs and eight suggested some sort of facility for drinks or snacks. Twenty-five suggested improvements in the entertainment available (better magazines, TV, radio) partly to pass the time but also because waiting, and in particular waiting in silence, is stressful.

"No music playing – feels like you're sitting waiting for the CHAIR – silence kills me."

(Male, 24 years)

"...too quiet, seems like you're waiting for someone to die ... everyone staring, nothing to do."

(Male, 23 years)

A number of clients reported leaving the clinic while waiting to be seen because the wait generated such anxiety. The importance of the entertainment available in the waiting room was to help clients to 'calm down'.

"If someone came in nervous or anxious they would go out of their minds having to wait so long without anything to do."

(Female, 22 years)

"The waiting room and atmosphere were very doom and uncomfortable, the build up of waiting so long to see someone is unbearable. My friend started to feel very uncomfortable and had to go outside."

(Female, 16 years)

The silence in the waiting room also had implications for confidentiality. Although receptionists are trained not to discuss clinical issues in reception at all, they do ask for names and addresses, and those who require condoms may have these dispensed by the receptionist and must inform her of this. Thirty clients commented on their embarrassment when giving personal details at reception. Most felt extremely uncomfortable even giving their name and address.

"Everyone knew my name after the receptionist had finished talking. I was not happy."

(Female, 19 years)

"Once out of the building felt very relieved that I had got away from all the eyes in the waiting room."

(Male, 16 years)

As a result of this embarrassment one client gave a false name and address, one reported that a friend had done so, one had considered doing so but decided against it, and two users had obtained contraceptives for friends by pretending that they needed them themselves.

The clinic is open long hours and operates a drop-in service (no appointments). The unpredictability of demand means that the waiting times are variable. Thirteen clients reported that they liked the drop-in service and two would have preferred appointments. Twenty reported that waiting times were too long and 11 found them acceptable. It was often the combination of long waiting times and the stressful atmosphere in the waiting room that caused people to leave.

"Waited for ever. That's when I felt like going. Back in the waiting room, sat there for a time. I left after this. Couldn't wait to see the doctor. I'm not a patient person. My friend got pills for me. She pretended she was me. Need more staff, can't wait forever. Myself and loads of my friends have got pregnant cause we cannot face waiting for doctors, such a long thing. Rather take the risk than wait on doctors and nurses."

(Female, 16 years)

Those who felt comfortable in the waiting room were more likely to stay to be seen.

"I don't mind the wait my friends were there with me."

(Female, 15 years)

"Waited an hour to be seen, it was quite busy. I spent an hour in deep conversation with my friend and reading magazines, which were informative and interesting."

(Female, 21 years)

Clinical consultation

Twenty-seven clients were happy with the quality of their consultation, five were unhappy and nine had a mixed response. Four did not see either a doctor or nurse as they came for condoms only and one did not wait for the clinical consultation. Clients were much more likely to comment on the attitudes of staff than to make assessments of their knowledge or technical competence. Those who were satisfied commented on the non-judgmental approach of staff (15 clients) and on being listened to (10 clients).

"The nurse (she) made me feel relieved and confident in what I was doing. The nurse gave me a choice of contraceptives I could use she did not force me to do anything or use anything I did not want to. I found her very helpful, informative, professional."

(Female, 21 years)

"They seem to actually care about you and not just listen to you because it's their job. They talk to you like an adult even though you're not supposed to be having sex. Always give you what you need and comfort you when you're worried."

(Female, 16 years)

Those who were not satisfied used the same criteria to express their dissatisfaction. Nine commented that they had not been listened to and five felt that staff were judgmental.

"...tried to persuade me that my ideas weren't good. I didn't feel listened to or taken seriously.... Professional advice is one thing but trying to influence an opinion is different."

(Female, 24 years)

"Asked for a pregnancy test and the same nurse made me feel stupid. 'You're on the injection, you don't need a pregnancy test' as if to say 'silly girl' – I must know what I want and how I feel, not her."

(Female, 16 years)

"My friend had a really rude nurse – she made her feel like a peanut! Even I felt stupid for her, so imagine how she felt."

(Female, 16 years)

Mission accomplished

Clients reported a sense of relief after the consultation. Their sense of relief suggests the extent to which they anticipated that the clinic visit would be difficult although

for some it had been better than anticipated. They reported their pride at having accomplished a difficult thing.

"After seeing it all done I felt relieved and had a fag. Felt glad that I had come." (Female, 17 years)

Staff responses

The response rate from staff was 11/22 (50%). Responses were anonymous so we have no information about the roles of those who responded. Staff were generally positive about the client consultation exercise. In response to the question 'What do you think about the survey' eight welcomed the attempt to involve users (*"excellent idea - more likely to get the responses"*) and three expressed reservations about the potential for change.

"Are any of the suggestions going to be put into effect, if not, money could be better used elsewhere (staff surveys bring about little change)."

"It is a waste of time if none of the suggestions are acted upon."

"Unrealistic."

Their views on the barriers to change were developed in response to the question on whether they felt the client views documented to be 'justified'. Most staff agreed with clients' reports.

"Justified at busy times - even the staff can feel intimidated by the silent stony stares in the waiting room."

However, several cited practical difficulties in responding to suggestions. These comments imply an assumed conflict between staff and client needs.

"...difficulties in implementation re vandalism and TV/radio drives people mad (including doctors)."

"...nice, blue carpet and more drinks and snacks machines are hardly compatible. See the state of the waiting room at the end of the day."

"I have tried magazines they steal and vandalise them. Many clients bring their own food and drink to the clinic and leave the remnants over the floor and over the chairs for someone else to clear up. It can be quite disgusting at times so as for drink and food and a nice, blue carpet - I don't think so."

All staff agreed that the waiting times are too long and most identified this as the key problem for the service. They felt that increasing the number of clinic staff was the best solution. Five of the 11 respondents suggested that more staff were needed.

"This is the real problem. If there were more doctors/nurses clients would not wait as long and hence would not be so concerned about décor/entertainment."

"It goes back to more staff - all spare money should be ploughed into this."

Several felt that the clinic was accessible despite the long waiting times.

"Yes they can be long - but how long does it take to get a GP appointment? We give holistic sexual health care. I think that clients are lucky to get this on a walk-in basis. I can't believe that people have taken risk/got pregnant instead of waiting!"

"Yes they can be long but at least they are seen and they know this."

Staff were concerned about the reports about judgmental attitudes and requested more information.

"It would be interesting to have feedback on own consultations. Would the client and professional agree? Do we have a real sense of how our clients feel?"

The section inviting general comments clearly illustrates the differences in attitudes between individual staff members. Clients' priorities were expressed in terms of the whole experience of service use rather than a narrower view of the medical services provided. Some staff accepted this alternative view and others did not.

"We mustn't underestimate how scary going to the clinic is - and try to be non-judgemental."

"It might help if individuals realised that the clinic cannot run for their own personal needs ... staff do not have the time to worry about keeping clients happy and content. We run a professional medical service not the local community centre."

Discussion

The user consultation

Our research demonstrates the practical feasibility of users interviewing users as a data collection strategy for measuring client satisfaction. The interviewer recruitment and training process was straightforward and no breaches of confidentiality were recorded. The quotes from the interviews suggest that the atmosphere of these conversations was informal and friendly and that clients were willing to share personal information in this situation.

It is predictable that clinic visits will include positive and negative elements and this methodology enables these to be documented rather than asking the client to generate composite ratings of satisfaction. The process of data transcription and analysis was less intensive than that required from in-depth qualitative interviews since there was some selection of material by both client and interviewer during the interview. The conversation was not reported verbatim but key elements and quotes were jointly identified as important by interviewer and respondent and recorded.

The experiences reported by clients are very similar to those recorded in other services^{1,16} and this raises questions about whether this approach offers advantages over traditional methods of measuring client satisfaction. The similarities are the identification of clinic environments and staff attitudes as important to young people and the importance of friends as a source of information and support during service use. What appears unusual about this approach is its ability to generate a detailed description of a specific service from clients using that service that includes negative experiences and suggestions for improvement. Most studies reporting negative views of contraceptive clinics have been conducted away from the services themselves and therefore generate general comments on a type of service rather than specific comments on a particular clinic. The latter may be of more use to service providers. For example, a recent survey of school pupils in the area where this clinic is situated shows high levels of dissatisfaction with most sources of contraceptive advice. Comfort with service use rated at 50 on a visual analogue scale of 1 to 100 for general practice, FPCs and dedicated youth services.¹⁷ Clinic users interviewed at clinics tend to express high levels of satisfaction with services possibly because of a tendency to associate university-trained researchers with the service studied and a reluctance to criticise those on whom they are dependent for care. It is therefore difficult to get reliable feedback on a particular service from service users. Peer

interviews may be one way to generate honest and specific feedback from clients and practical suggestions for improvement.

The extent to which clients focused their attention on the clinic waiting room is the second unusual aspect of the data presented. No guidance was given to the interviewers in terms of how much of the interview should be allocated to each aspect of the clinic visit and the waiting room elicited far more discussion than the consultation. This may be because much more time is spent in the waiting room. Two-hour waits are not unusual and the consultation may last only 10 minutes. In addition, clients may feel competent to judge the waiting room facilities and communication skills of clinical staff but less able to judge clinical skills. Many will have had experience of decorating their own homes and were clearly comfortable discussing colour schemes, carpets, furnishings, plants and pictures. This study was completed soon after redecoration of the clinic waiting room and it is clear that the redecoration did not meet clients' needs. This may be because the waiting room was refurbished with reference to an unrealistic assessment of waiting times. While upright chairs, little entertainment and no refreshments may be acceptable in situations where clients are waiting less than half an hour, long waits generate very different requirements. The redecoration did not attempt to disguise the room's function as an NHS waiting room and this approach is apparently at odds with the views of some users who would appreciate the creation of a more homely atmosphere.

The tendency of clients to comment on the interpersonal skills of staff rather than their technical competence is consistent with the literature on client satisfaction.¹¹ It might have been possible to stimulate more extensive comments on experience of the medical care provided with more support and prompting and this question requires further evaluation. Our results indicate that a significant minority of clients experience negative attitudes from staff. Judgmental attitudes from staff in community FPCs are an important barrier to service use by those at risk of unintended pregnancy and are well documented in this setting.¹⁸ This study confirms their persistence among a minority of staff.

Staff responses

Client satisfaction studies in the NHS have been criticised in terms of their limited ability to stimulate change.⁷ This is often a consequence of the conflicting views of clients, staff and managers on the merits of possible developments.¹⁹ This conflict is reflected in our data. Whereas clients prioritise the clinic environment and staff attitudes, staff imply that these are extra to the core clinical service.

Changes to clinic hours and opening times in this service and an extensive outreach programme have resulted in large increases in the number of clinic users.²⁰ This has had both positive and negative effects for staff. Clinics are busier and staff work harder but the smooth running of the clinic has improved as routine ordering and the processing of test results has been taken on by a full-time administrator. Staff also report feeling less isolated. More than one doctor, nurse and receptionist are usually working at any one time and this facilitates the discussion of clinical cases and the sharing of administrative problems. The clinic has become a popular place to work and is perceived by staff as having a good atmosphere. However, the very large increase in the number of clinic users has generated concern about strategies that might make the clinic even busier.

Clients and staff also have potentially conflicting

priorities. Whereas staff are keen that the waiting room should appear tidy, clients require refreshments or children's toys that generate mess. Staff see the clinical service as the most important aspect of a clinic visit while users may view their comfort while waiting for long periods as equally important. Those who have worked to develop the service may feel that clients are lucky to access it while clients feel that they have a right to do so.

These perceived conflicts have impeded the implementation of the improvements suggested by clients. Further work is required on identifying common goals for staff and clients. Long waiting times and a poor atmosphere in the waiting room have negative impacts on both groups. Strategies to increase clinic access must be coupled with strategies to improve clinic throughput and staff concerns about their ability to respond to the remaining local unmet need for contraceptive services must be taken seriously as the service is developed to meet this need. An iterative process of staff and client consultation is required to ensure that service development proceeds in a direction that meets the needs of both groups.

Statements on funding and competing interests

Funding. This work was funded by a grant from the Charitable Foundation of Guys and St Thomas' Hospitals.

Competing interests. None identified.

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